DER
H
1
039

w/r

WELFARE in REVIEW

November--December 1968
Volume 6 Number 6

The Health-Care System and the Poor
A Social Organizational Point of View

Measuring the AFDC Family's Potential for Economic Independence

1968 Index of Authors and Subjects

U.S.
DEPARTMENT
OF HEALTH,
EDUCATION,
AND WELFARE

Social
and
Rehabilitation
Service

WELFARE in REVIEW

Welfare in Review is published six times a year by the Office of the Administrator, Social and Rehabilitation Service.

Statements in Review articles do not necessarily reflect official policies of the Social and Rehabilitation Service.

Suggestions or comments should be addressed to the Editor, Welfare in Review, Social and Rehabilitation Service, 330 Independence Avenue, S.W., Washington, D.C. 20201.

Contents of the publication are not copyrighted; any items may be reprinted but citation of Welfare in Review as the source is requested.

Use of funds for printing this publication was approved by Director, Bureau of the Budget, July 22, 1963.

Welfare in Review is for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Price $1.75 a year; $2.25 for foreign mailing; single copies, 35 cents each.

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

WILBUR J. COHEN, Secretary

SOCIAL AND REHABILITATION SERVICE

MARY E. SWITZER, Administrator

JOSEPH H. MEYERS, Deputy Administrator

GENEVIEVE W. CARTER, Chief
Division of Intramural Research

CATHERINE P. WILLIAMS, Editor

Volume 6 Number 6

NOVEMBER-DECEMBER 1968

In This Issue *Page*

The American Health-Care System
A Social Organizational Point of View 1
Otto M. Reid, Patricia Arnaudo, and Aurilla White

Measuring the Potential of AFDC Families
for Economic Independence 13
Harold A. Morse

Public Opinion and Public Welfare 19

Book Note: The ITPA Test 20
New Publications 21
Program and Operating Statistics 23
INDEX of Authors and Subjects, 1968 48

The American Health-Care System and the Poor

A Social Organizational Point of View

OTTO M. REID, PATRICIA ARNAUDO, AND AURILLA WHITE

The need for a systematic examination of the Nation's health-care system is growing steadily and with considerable urgency. Of vital concern in determining what health care is readily available and how effectively it is organized is an understanding of many of its essential aspects such as the way in which health-care units and health-care practitioners are organized into health-care systems. Also of vital concern in such a determination are the fact that the health care the poor receive is farther from adequacy than that of persons at higher income levels and the belief that it may be more nearly accurate and more useful to attribute this fact to the design and activities of the health-care system rather than to the attitudes of the poor. In this article we will discuss these vital issues.

Health-Care Problems and Practices

Low-income persons have more health-care problems than persons at other income levels; their health-care problems are often more severe and longer lasting; and they use health-care services less frequently.[1] The most obvious deficiency in their use of health-care services is failure to use these services to prevent illness and to seek advice as soon as they should. Rather, they tend to use services only after illness has become serious.

Although many of the health-care problems of the poor can be attributed to the direct effects of poverty--to inadequate diet, bad housing, poor sanitation, and overcrowding--many are due to underuse of health-care facilities and services.[2] For the poor the cost of services has been a major barrier to full use, especially when preventive measures and aftercare are concerned.

The cost of health-care services, however, has not been the only great barrier. Even when free care is available, the poor use health-care services less frequently than others (though some of the differential in use declines[3]), and they tend to use them only after medical conditions are serious.

The poor more often use unacceptable and inadequate health-care services than persons at other income levels. Particularly when pain or discomfort is minimal, they are likely to seek advice from friends or relatives or the corner druggist rather than from physicians. They are more susceptible to the lures of medical quacks and faddists, and they are more likely to try to treat themselves and to use home remedies.[4]

The Psychological Point of View

Why do the poor fail to use health-care services as they should? The fault may lie in them--in their individual psychology--or in the system--in the way health-care is organized and delivered.

Dr. Reid is Chief, Long-Range Research Branch, Intramural Research Division, Office of Research, Demonstrations, and Training, Social and Rehabilitation Service. Mrs. Arnaudo is a social science analyst in the Office of Juvenile Delinquency and Youth Development, Social and Rehabilitation Service. She formerly served in the same capacity in the Intramural Research Division. Mrs. White was a social science analyst with the Intramural Research Division at the time this article was prepared.

In the past it was common to seek explanations for the health-care practices of the poor through the study of the individual characteristics of the potential recipients of such services. Research has shown that the deficient use of health-care facilities is associated with, if not explained by, a person's beliefs, opinions, attitudes, motives, and personality.[5] The low-income person frequently lacks knowledge of or information about physiology, medical etiology, good health practices, and the work of the health-care practitioner.[6] He often lacks ability to use information intelligently or to follow the practitioner's advice. And he is more likely than persons at other income levels to have inaccurate information concerning health and the treatment of disorders, to be more fearful of ill health and of using health resources,[7] to be more uncomfortable in health-care facilities, and to be more distrustful of practitioners.[8]

Some investigators link deficient use of health-care facilities to particular ethnic origins, social class, and cultural background.[9] Others link such individual characteristics to the particular life situation of the poor in the United States.[10] Still others hypothesize a generalized worldwide culture of poverty to account for why the poor everywhere are more ignorant about important aspects of living such as health and are more apathetic toward or distrustful of actions designed to remedy their situation.[11] Other investigators have found an apparent connection between the readiness of a person to act to safeguard his health and his perception of the likelihood of illness occurring, the seriousness of the illness, and the effectiveness and feasibility of treatment.[12]

All-out health education programs might seem to be the answer. But health education programs directed at persons with inappropriate attitudes, especially low-income persons, have shown disappointing results.[13] One difficulty is that the persons most in need of health education are those least likely to be reached or convinced by education--those who cannot or will not read, those who read the wrong things, those who reject information inconsistent with entrenched beliefs and opinions, and those who are emotionally dependent on beliefs that forbid them to consider other points of view.

Explaining health-care practices through psychological or individual characteristics has its use, particularly as a means of pointing out the directions programs might take to shape practices. This is especially true when characteristics spring from social milieu.

The Organizational Point of View

Another method of accounting for the health-care practices of the poor is to describe the logical consequences of the health-care system in operation. It may be more feasible to count on changing the practices of organizations that influence the attitudes of clients than to count on the reverse sequence.[14]

Medically desirable behavior can be affected by the social interaction required of the person in need of care and the way in which health-care units and health-care practitioners are socially organized to dispense health care.[15] A person learns what to do about health and health problems from others. Likely, interaction with health-care practitioners in health-care settings shapes many of the attitudes, thoughts, motives, and practices of people concerning health care. The way in which health-care practitioners deal with low-income persons and the way health-care units are organized are vital in determining what health care is readily available and how feasible, convenient, and free of problems it is to use.[16]

Many insightful descriptions (but as yet few research findings) indicate that the health-care practices of low-income persons are often due to these conditions: the behavior of health-care practitioners is often not the same with low-income persons as with persons at other income levels and the kinds of health-care practitioners who deal with low-income persons are usually different from the kind who deal with others; typically, low-income persons are served in social-medical

settings far different from those used by others; and social attitudes favor the client who can pay his way and handicap those who cannot.[17] In other words, the practitioner, the setting, and the attitude of the general public have much to do with the poor health practices of low-income persons.

Health-care practitioners.--It is logically possible to account in part for the inadequate health care the poor receive by focusing attention on the actions of a different group of persons--the health-care practitioners. Although deficient health-care practices may be due to the inadequate attitudes, motives, and the like of the poor themselves, they might also be due to the attitudes, motives, and practices of health-care professional persons that interfere with the delivery of good services to the poor. The major thesis of this article, however, is that ultimately the attitudes, motives, and practices of both the poor and the health-care practitioner are powerfully shaped by the way in which health-care units are organized and the organizational structure that links units together. Both health-care practitioners and users of service can only partly overcome the limitations of the compulsion exerted by the system.

Health-care units.--Several studies point out that, in the specific use of the term social organization, the kinds of medical units used by low-income persons *are* different from those used by others. Low-income persons are more likely to get health-care services from more poorly staffed and inadequately equipped hospitals than are other persons and to be treated by health-care practitioners with lesser academic qualifications and heavier work loads.[18]

American society and culture.--Social influences affecting the use of health-care services can include not only interpersonal relations but also the abstract extrapersonal characteristics of social structure, social organization, and culture. Social structure affects both the health and the health-care practices of low-income persons in that many of them live in urban slums or in isolated rural areas poorly supplied with health-care facilities and health-care practitioners, both in number and in quality. Unemployed persons and persons employed in short-term jobs and jobs requiring little skill are unlikely to have employer-supported health insurance or facilities. The child of a migrant worker is less likely than the child of a worker in a geographically fixed occupation to find himself in a school providing periodic health checks and medical referral or to have a regular source of medical care.

The cultural characteristics of society in the United States affect both the nature of the health-care system and the place the low-income person has in it.[19] Americans seem to value more than any other a fee-for-service system in which private practitioners care for those who can pay for service. A different form of delivering health-care services is typically provided for those who cannot pay out of pocket or by health insurance. Other cultural characteristics affecting health care may also include such social attitudes as the belief that wealthy and important persons are entitled to more costly goods and to better services than others because they have earned it and that persons without money should be grateful for whatever free services they receive.

Moreover, many Americans relegate the poor in general and some poor persons in particular--usually Negroes and Spanish-speaking persons--to lesser consideration. They feel that poverty, especially in the midst of wealth, reflects such undesirable characteristics as slothfulness or desire to exploit the rich. They have unfavorable attitudes toward persons they consider immoral, slovenly, or hostile. Health-service practitioners do not escape from having such bias: many of them reluctantly work with the poor.[20] The public tends not to be outraged by the delivery of less than adequate health-care services to the poor and is less likely to support action to change conditions than when the inadequacy works against middle and upper class persons. Part of the problem is the matter of dis-

tribution. Some experts maintain that there are not enough licensed and practicing physicians or other health-care specialists to provide health care for all persons in the United States. Others emphasize the fact that the geographic distribution of health professional workers and their availability to low-income persons are far from equitable.[21]

Their effect on the poor person.--At the least a person's characteristics probably interact with organizational influences to cause certain kinds of behavior. The low-income person may be more reluctant to use health-care services than others in large part because such services *actually* are less convenient and costlier for him than they are for the middle- or high-income person.[22] Even when basic medical services are available at no cost, he must spend more time and face more inconveniences to get to services; he must wait longer and in more dismal and uncomfortable surroundings for services; and he is more likely to have to go to several locations to receive care.[23] Transportation and incidental medical costs, although smaller for him than for others, take a larger portion of his assets. The higher income person is often permitted to take time off with pay from work to get medical care, but the low-income person on hourly wages often loses income when visiting health-care facilities during working hours.

The small faith in medical practice that low-income persons seem to have may derive from this fact: services are less accessible to them and are of poorer quality than those received by paying clients. They may lack confidence in physicians because those they see are not so competent or so eminent as those paying clients see or they are not furnished a single and primary physician with whom they can have a continuing relation.[24]

The attitudes of all persons toward health-care are not always rational, of course, be they rich, middle class, or poor. Many persons grow less willing to see a physician the more convinced they are that something is seriously wrong with them.[25] The low-income person, however, is more likely to be correct in his assessment that he has many serious complaints and that for one reason or another he will not be able to follow the physician's recommendations.[26]

What we are saying is that from a social organizational point of view the attitudes, thoughts, and motives of the poor that inhibit desirable health action could be conceived of as consequences of the operation of the social system generally and of the health-care system specifically, rather than as ultimate explanations of their inappropriate health-care practices. It may be the health-care system itself, reflecting social attitudes, that limits the pursuit of preventive health-care measures by low-income persons, particularly when individual initiative is required, and makes it less desirable or beneficial, at least in their minds, for them to use the health-care system.

The Organization of the System

Before we can discuss how the health-care system can be changed to bring better health-care services to the poor we must look first at the system as it now operates. We particularly need to look at how it is organized to serve the poor.

Health care in the United States is delivered through a complex system of organizations such as hospitals, clinics, and health-care centers, as well as through individual practitioners. The relation of these practitioners to the organized health-care system varies greatly; some work exclusively within organizations, others work almost independently.[27] But even the most individualistic practitioner is dependent on a network of organizations and services and on other practitioners for aid, advice, and service. Virtually all physicians are part of the health-care system of a particular community and of the Nation as a whole--a system whose parts are more or less independent but which in its entirety provides for the Nation's health care.[28] Although the health-care system is often a

cooperative effort, competition for services and resources (and even for the most desirable clients) exists.

Structural arrangements through which health care is delivered to various kinds of persons vary greatly in the United States. Physicians may practice in groups, by themselves, or in hospitals; they may be salaried or independent or be in partnership; they may teach or conduct research; or they may hold that serving a heavy and extensive patient load in community-supported health units is the role that best expresses their professional commitment. Hospitals and other health-care settings also vary in objectives and sponsorship; some are organized to treat large groups of patients as efficiently and inexpensively as possible; some are affiliated with medical schools and postgraduate educational centers; others are managed and controlled by the physicians who practice in them and offer little opportunity for objective evaluation of practices; some are large, others small; some emphasize community medicine and continuity of care; some have large endowments and are heavily supported; others barely survive economically from day to day.

Any complex system of social service develops through the collective efforts of many persons and groups. As the outline of the system becomes codified in the social structure, social organizations operate by more or less recognized blueprints. Ideally, hospital staffs, physicians and other health-care practitioners, pharmacists, members of public health units, and members of health-care policy organizations are all involved in a complex network of operations aimed at meeting the Nation's health needs.[29]

It is neither possible nor desirable to specify a "best" model of structural arrangements for patient care.[30] Some attributes of the social organization of care are not easy to evaluate. Within each kind of arrangement, undoubtedly some health-care units give excellent care. Practitioners in some hospitals and in private practice do treat low-income persons, as do many tax-supported hospitals.

The System and the Poor

Persons in need of health-care services cannot invent or create what they need--they must choose or accept services from what is available. In a society as complex as ours, the choice is often not free: a man's position in society determines how much he knows about resources, what part he is informed about, and what parts he is encouraged or even permitted to use. This rule in operation is apparent in the health-care practices of the poor and the way health-care is delivered to them.

Low-income persons frequently receive ambulatory care in the out-patient clinics of public and voluntary hospitals with free clinics, and they tend to use emergency clinics as their source of health care (because emergency clinics have unlimited hours and do not require appointments).[31] The implications for the kind of health care they receive are many. For certain it tends to be different from and inferior to that delivered to the paying patients of physicians with hospital staff privileges.[32] The services they receive are often impersonal, fragmented, and inferior.

The structure of the typical clinic almost insures that the low-income person will be attended by a health-care practitioner who knows little about him as a person or about his medical history. Particularly in hospitals not affiliated with universities, the attending physician may be an intern with little medical experience. With the exception of a few university hospitals, senior physicians supervise junior staff members in rotation. Even the best teaching hospitals have supervisory problems. In some public and community hospitals, many junior staff members are physicians trained in foreign institutions, some of which are generally regarded as less capable of offering good training than U.S. institutions, or in the less highly regarded U.S. medical schools. The attending physician, even when a highly qualified and a full-time staff member, is likely to have a much larger number of patients than those caring

for paying patients. Further, the poor are sometimes regarded as "teaching material" from whom interns and resident physicians acquire practical experience.[33]

Even the well-trained, full-time physician in the high quality university-affiliated hospital--if the hospital depends on public funds--is likely not only to have a large patient load but also to lack the helpers, supplies, and facilities he needs. Many dedicated physicians eventually leave such facilities because they feel they cannot continue to deal with the frustration of attempting to treat seriously ill patients without good resources.[34] Because of such conditions, the kind of health care delivered in clinics, especially in emergency clinics, tends to be fragmented or at best episodic.[35] Moreover, even if the practitioner is able to provide excellent care for the immediate complaint, he may be forced to give fragmented care because he can give little or no time to the patient's condition in other respects or to followup care. In many cases the followup care is given by another physician.[36] Preventive care, particularly diagnostic screening, is rarely furnished in such settings.

Further fragmentation of services arises in that it is often necessary for the adult members of a family to go to separate clinics depending on the kind of illness--the mother to a prenatal clinic, the father to a general clinic, for instance--and to take the children to still other clinics--for well baby services and for pediatric care. The inconvenience of the process sometimes results in overlooking the "less serious" health-care problems of some of the family's members. It also means, occasionally, that the potential influence of the health problems of one family member on other family members is overlooked.

Units serving the poor are often their last or only resort. If they are turned away, they have nowhere else to go. The person paying for care more often obtains the services of a board-certified physician affiliated with a medical school who can call on other board-certified specialists as needed.[37] He is more likely to receive instructions about health care than the patient using free services. He tends to get clearer instructions because he and the physician speak a similar language and have more in common.

Except in a few recently established programs, the charity patient does not have a personal physician. Rapport tends to be low between physician and patient.[38] The physician is usually too busy to instruct the patient or to be concerned about the possibility of later medical complications, and he has trouble making the poorly educated patient understand his instructions.

The client who is poor is not in the habit of asking the physician to clarify instructions. He is often unable to judge what is good care and is less able than others to effectively object to what he may see as inadequate diagnosis, treatment, or explanation. He is less able to demand that the physician reconsider what he has done. The low-income person is often referred to medical services by a social worker, a person who does not have the same amount of knowledge about medical resources as a physician and who often does not have time to add concern for such matters to activities more nearly central to his profession.[39]

Health-care units receiving full payment for services from clients can compete successfully for the best qualified practitioners, can hire a sufficient number of ancillary workers, and can purchase necessary supplies. They can turn away applicants when they are overloaded or can restrict their services to specialties. In contrast, administrators of health units supported primarily by taxes, who must justify their requests for funds to taxpayers and government officials, are at a competitive disadvantage when resources are scarce.

Research into Organization

In recent years the amount of literature bearing on the theoretical foundations of the operation of social organizations has grown to considerable proportions. The effort involved in producing these

works and the thinking behind them have truly represented many fields and professions, and has included representatives of the fields of sociology, political science, psychology, business management, economics, and even the physical sciences and mathematics.[40] These theoretical efforts have only infrequently been focused on the study of health and welfare units or on the operation of the health-care system.[41] The integration of theory with the practical study of those concerned with improving health care is one of the most vital research steps in the Nation's efforts to find answers to current problems in the health-care field.

Research problems centering on the social organization of health-care services and of the health-care system itself are many. It would serve no purpose to try to draw up a comprehensive catalog of the research needed, but it should be useful to indicate some aspects of research problems that seem important and timely. Three particularly important aspects concern intraorganizational characteristics, interorganizational relations, and changing behavior through organizational change.

Intraorganizational characteristics.--Social organizational theory has had much to say about the consequences of the structural characteristics of organizations on their ability to function (and the manner in which they function) and on the way they deliver services.[42] Research on health-care services is needed to delineate the consequences of such characteristics as size, hierarchical structuring, physical arrangements, and method of coordinating complex services on the quality of health-care services and the efficiency and effectiveness with which such services can be delivered. Typical interactions, both between health-care workers and between them and their clients, have many unknown implications for meeting the purpose of the units in which they operate.

The many insightful hypotheses about the consequences for health-care when delivered in various organizational settings need more explicit verification by experiment. The proposition that the settings in which low-income families typically receive health-care relegate them to fewer and poorer services requires more definite confirmation by carefully controlled research. Whether less common organizational methods such as prepaid group-practice plans continue to show the superiority indicated by some groping research comparisons is also a question of considerable interest to those concerned about the health-care system and its effects on the poor.[43] The consequences for the cost, quality, and effectiveness of health-care services of various current and proposed health-care delivery and financing mechanisms constitute an important field for research.[44]

Interorganizational relations.--Some of the more complex research questions involve the study of how diverse individual social units and social organizations operate and how they can be welded into effective and efficient systems for delivering health-care services. We need to find out under what circumstances interagency cooperation and coordination are most likely to be achieved and how barriers to such coordination can be minimized or eliminated.[45] Social organizational theorists have indicated that competition among units may be constructive as well as restrictive.[46] The limits within which the competition facilitates or interferes with the accomplishment of local and national purposes need to be identified. Specific research could include examination of contrasting communities in which health-care units form an effective chain as contrasted with those in which relations are minimal and cooperation is rare. The role of welfare and other kinds of social agencies, a role commonly defined as the identification and referral of persons in need to the most appropriate source of service, requires study as a potentially powerful locus for coordination.

A research question at once of great consequence and complexity is how decisions are made concerning the allocation or withholding of resources required to meet national or local needs such as the expansion of resources for delivering more and better health-care services.

Social organizational theory is beginning to recognize that individual organizational units and even whole systems operate in a physical and social environment, just as do individual persons.[47] Research is needed to determine to what extent and in what ways the operations of health and welfare units and the health-care system are shaped by social forces lying outside their boundaries. Indeed, questions asked and answered by agents for such influential social groups can sometimes become research questions in themselves. In point would be questions such as whether, with limited national financial resources, expenditures to improve the national system of health-care service do more or less to promote health than comparable expenditures to assure that everyone has enough money to follow a healthful diet. Would comparable funds spent for other measures--say, to persuade people to drive with safety belts fastened, or to carefully control their weight, or to stop smoking cigarettes--more effectively improve health? [48]

Changing behavior through organizational change.--A major purpose of Federal expenditures for health is to change the health status of the Nation's citizens and to distribute health resources more equitably among all.[49] Social organizational theory (and expressions of the insight of many members of the health-care system) suggests many possibilities for improving the health-care practices of the poor through changing the organization of health-care services to make them more rewarding than they have been--to improve the quality of care delivered, to make facilities more pleasant and convenient, and to assure more nearly adequate communication between health-care practitioners and the low-income client. Research must be designed to test the efficacy of such efforts, as well as to test whether other choices suggested by critics of the system succeed in generating new emphasis among low-income families on using health-care resources to ward off illness and to seek treatment long before symptoms leave no alternative.

Critics of the system have suggested a number of changes in the method of operating health insurance programs and health-care units capable of generating change. Questions as to the most effective role of service workers, who are generally community resource persons rather than specialists in a particular field such as health, have relevance for this issue. For example, visiting nurses, social workers, rehabilitation workers, home health aides, and Office of Economic Opportunity neighborhood service workers are all suggested by persons in health, government, and research agencies as crucial in promoting better use of health services and in maintaining health. The problems of how to make the best use of such resource persons is a field of study promising useful results.

SRS Research: Effects of Title XIX

The Title XIX Medical Assistance Program (Medicaid) of the Social Security Act, administered by the Social and Rehabilitation Service (SRS), aims at reducing, then removing, the major barrier--lack of money--to the receipt of good health care by persons in low-income families. Once this barrier is removed, the aim can shift to the effective use of free or low-cost health-care services.

The Intramural Research Division of SRS, working with the research staff at the Graduate Schools of Public Health at the University of Pittsburgh, is investigating the extent to which Title XIX and other Federal health-care programs are generating changes in health-care units, in the practices and procedures of health-care practitioners, and in the health-care delivery system. A complementary project, on which SRS is working with the School of Public Health and Administrative Medicine at Columbia University, is investigating whether Title XIX is favorably affecting the health-care practices of low-income persons. The Columbia project will investigate how use of services looks to the low-income recipient, whether he sees the receipt of services under the Title XIX program as having

undesirable consequences, and whether he still meets barriers in his search for health care. For instance, it will try to determine whether he is now more ready and able than formerly to use health-care services at more appropriately early stages in the development of health-care problems.

The University of Pittsburgh's research will focus on the agencies, persons, and procedures for delivering health care to Title XIX recipients and to others in low-income families. Research questions cover a wide range of theoretical and practical considerations. Can an all-out effort by the Federal Government promote desired changes in organizations and systems, even though much research has shown a powerful resistance to organizational change?

Critical research questions in this respect concern whether increased financial support for health-care units provided through Title XIX programs (as opposed to the old medical vendor payment programs) is sufficient in itself to improve their capacity for delivering better health services to more persons and whether State and local governments are thereby enabled to increase all local effort for health care. The research will examine the effect of the permissible range of Title XIX programs adopted by each State and of the particular administrative arrangements developed for easing or obstructing Federal objectives for the program.

The Title XIX program may achieve the effects desired by increasing the resources, facilities, and capability of health-care units that have been serving the poor or by providing incentive to encourage other health-care units to serve the poor. If so, it will relieve the burden on such units. The research will be alert to both possibilities.

Generally, the research will be sensitive to such improvements in health-care services for the poor as this: an increase in the numbers of low-income persons receiving higher quality care with greater (and more appropriate) frequency under circumstances less likely to discourage search for such care. It will examine whether both health and welfare agencies give more effort than before to identifying persons in need of health-care services, whether referral procedures will be more nearly precise, whether organizations will develop more concern for ensuring adequate followup of health-care services, and whether social services are more freely and appropriately provided to support the therapy required. In this research it will be crucial to determine whether effective cooperation between health and welfare agencies is being achieved. The research design will include a baseline examination of a national sample of communities at an early stage of the Title XIX program to provide benchmarks against which to assess later change in the capability of health-care units to deliver health-care services to the poor, to increase the number of units delivering services, and to increase the amount and quality of health-care services delivered.

The research we have described in this article represents an untypical and potentially valuable method of interfacing intramural and contract research. The original development of the scope, focus, and purpose was carried on in the Intramural Research Division. It was further developed in close collaboration with the research staff of the contract agencies. A Medicaid Research Advisory Committee, composed of experts on research from universities and hospitals and research and program staff members of the Federal agencies concerned with the advancement of knowledge about health care, provided consultation in perfecting the plan. The collaboration between the academic research contractor and the Government agency will, if its purpose is attained, coordinate the theoretical base essential to the design of superior research with the practical concern vital to decision-makers.

FROM the social organizational point of view, the flaws and weaknesses of the American health-care system are at the root of many of the inadequate health-care practices of the poor. However,

more research is needed to establish the utility of this point of view in promoting better health care. In this article, after taking a look at the health-care system and how the poor use--and are permitted to use--it, we have attempted to describe some of the unresolved issues and to suggest topics for research that could help resolve them. The research problems discussed, of course, are not the only ones needing resolution, but they are illustrative of some potentially important subjects. A social organizational point of view appears to offer a fresh and challenging method of reaching a better understanding of the operation of social organizations and systems of organizations generally and health-care organizations and health-care systems specifically.

---

[1]*Excellent documentation of the statistics of the status of health care and the use of health-care services has been done by the National Center for Health Statistics, U.S. Public Health Service. See especially--*

Medical Care, Health Status, and Family Income, Washington, D.C., U.S. Department of Health, Education, and Welfare, PHS Publication 1200, Series 10, No. 9, 1964.

Geraldine A. Gleeson and Elijah C. White, "Disability and Medical Care Among Whites and Non-Whites in the United States," Indicators, October 1965.

[2]*For data on differential use of health-care services by various income groups see--*

Daniel Rosenblatt and Edward A. Suchman, "The Underutilization of Medical Care Services by Blue-Collarites," in Arthur Shostak and William Gomberg, eds., Blue Collar World: Studies of the American Worker, Englewood Cliffs, N.J., Prentice-Hall, Inc., 1964.

Robert Nolan, et al., "Social Class Differences in Utilization of Pediatric Services in a Prepaid Direct Service Medical Care Program," American Journal of Public Health, January 1967.

John Ross, "Social Class and Medical Care," Journal of Health and Human Behavior, Spring 1962.

Jay Brightman, et al., "Knowledge and Utilization of Health Resources by Public Assistance Recipients," American Journal of Public Health, February 1958.

Eliot Friedson, Patients' Views of Medical Practice, New York, Russell Sage Foundation, 1961.

[3]*Earl L. Koos, The Health of Regionville: What the People Thought and Did About It, New York, Columbia University Press, 1954.*

David Mechanic, "The Concept of Illness Behavior," Journal of Chronic Diseases, vol. 15, 1962.

Daniel Rosenblatt and Edward A. Suchman, "Blue Collar Attitudes and Information Toward Health and Illness," in Arthur Shostak and William Gomberg, eds., op. cit.

[4]*For a good discussion concerning use of quasi-medical services, see--*

W. Richard Scott and Edmund H. Volkart, eds., "Laymen and the Medical Institution (Lay Belief Systems) (Part II)," Medical Care: Readings in the Sociology of Medical Institutions, New York, John Wiley and Sons, Inc. 1966.

Beatrix Cobb, "Why Do People Detour to Quacks?" in E. Gartly Jaco, ed., Patients, Physicians and Illness, Glencoe, Ill., The Free Press, 1958.

[5]*Herbert Gans, The Urban Villagers, Glencoe, Ill., The Free Press, 1962.*

Paul B. Cornely and Stanley K. Bigman, Cultural Considerations in Changing Health Attitudes, Washington, D.C., Howard University College of Medicine, 1961, vol. I, ch. 5; vol. II, passim.

Lyle Saunders, "Healing Ways in the Spanish Southwest," in E. Gartly Jaco, op. cit.

Mark Zborowski, "Cultural Components in Responses to Pain," in E. Gartly Jaco, op. cit.

Irving K. Zola, "Problems of Communication, Diagnosis, and Patient Care: The Interplay of Patient, Physician, and Clinic Organization," Journal of Medical Education, October 1963.

_____, "Culture and Symptoms--An Analysis of Patients' Presenting Complaints," American Sociological Review, October 1966.

[6]*Edward A. Suchman, "Medical 'Deprivation,' " American Journal of Orthopsychiatry, July 1966.*

Daniel Rosenblatt and Edward A. Suchman, op. cit. (both articles).

Lola M. Irelan, "Health Practices of the Poor," in Lola M. Irelan, ed., Low Income Life Styles, Washington, D.C., U.S. Department of Health, Education, and Welfare, WA Publication No. 4, 1966.

Jules Henry, "White People's Time, Colored People's Time," Trans-action, March-April 1965.

Albert K. Cohen and Harold M. Hodges, "Lower Blue Collar Class Characteristics," Social Problems, Spring 1963.

Edward A. Suchman, "Socio-medical Variations Among Ethnic Groups," American Journal of Sociology, November 1964.

U.S. Department of Labor, Office of Policy Planning and Research, The Negro Family: The Case for National Action, Washington, D.C., March 1965.

Lee Rainwater, And the Poor Get Children: Sex, Contraception, and Family Planning in the Working Class, Chicago, Quadrangle Books, 1960.

[7]*See footnote 2.*

[8]*Oscar Lewis, Five Families: Mexican Case Studies in the Culture of Poverty, New York, Basic Books, Inc., 1959 (introduction).*

_____, The Children of Sanchez, New York, Random House, 1961 (introduction).

Jerome Cohen, "Social Work and the Culture of Poverty," in Frank Riessman, et. al., eds., Mental Health of the Poor, New York, The Free Press, 1964.

[9]Herbert Gans, op. cit.
Paul B. Cornely and Stanley K. Bigman, op. cit.
Mark Zborowski, op. cit.
Daniel Rosenblatt and Edward A. Suchman, op. cit. (both articles).
John Ross, op. cit.

[10]Lola M. Irelan, op. cit.

[11]See footnote 8.

[12]Godfrey M. Hochbaum, Public Participation in Medical Screening Programs: A Sociopsychological Study, PHS Publication, No. 572, Washington, D.C., U.S. Department of Health, Education, and Welfare, 1958. (An early statement of a similar theory.)
Irwin M. Rosenstock, "Why People Use Health Services," Milbank Memorial Fund Quarterly, July 1966, pt. 2. (A later, modified statement of this general theory.)

[13]Camille Lambert, Jr., and Howard E. Freeman, The Clinic Habit, New Haven, College and University Press 1967. (These authors show that children who have used free dental clinics are, after they stop using clinics, more neglectful of their teeth than children who have never used such clinics.)
Benjamin D. Paul, et al., eds., "Trigger for Community Conflict: The Case of Fluoridation," Journal of Social Issues, vol. 17, No. 4, 1961. (Describes unsuccessful campaigns to alert people to the benefits of fluoridated water.)
Kerr L. White, "Organization and Delivery of Personal Health Services: Public Policy Issues," Milbank Memorial Fund Quarterly, January 1968, pt. 2.

[14]Recent reports on research findings about the health-care system include--
Howard J. Brown, "Delivery of Personal Health Services and Medical Services for the Poor: Concessions or Prerogatives," Milbank Memorial Fund Quarterly, January 1968, pt. 2.

[15]Avedis Donabedian and S. J. Axelrod, "Organizing Medical Care Programs to Meet Health Needs," Annals of the American Academy of Political and Social Science, December 1961.

[16]Richard H. Schlesinger, et al., "Outpatient Care--The Influence of Interrelated Needs," American Journal of Public Health, November 1962.
Avedis Donabedian and S. J. Axelrod, op. cit.

[17]For a discussion of discrimination against the poor in the health-care system, see--
Alonzo Yerby, "The Disadvantaged and Health Care," American Journal of Public Health, January 1966.
Dorothy Harrison, "The Health Care Situation--Summary and Recommendations," The Health Status of the Negro: Conference Proceedings, Washington, D.C., Howard University, March 1967.
Ozzie Simmons, "Implications of Social Class for Public Health," Human Organization, Summer 1967.
Talcott Parsons, "Social Change and Medical Organization in the United States: A Sociological Perspective," Annals of the American Society of Political and Social Science, March 1963.

[18]Apparently, there is little if any disagreement with such accounts as--
Mark Lepper, et al., "Approaches to Meeting the Health Needs of Large Poverty Populations," American Journal of Public Health, July 1967.
Alonzo Yerby, op. cit.
Howard J. Brown, op. cit.
John D. Stoeckle and Irving K. Zola, "Views, Problems and Potentialities of the Clinic," Medicine, May 1964.
Anselm L. Strauss, "Medical Ghettos," Trans-action, May 1967.

[19]Talcott Parsons, op. cit.
Milton I. Roemer, "Changing Patterns of Health Service: Their Dependence on a Changing World," Annals of the American Academy of Political and Social Science, March 1963.

[20]Irma H. Strantz and Winston R. Miller, "Development of Interagency Coordination in a Program of Comprehensive Medical Care," American Journal of Public Health, May 1966.
Alonzo Yerby, op. cit.

[21]Apparently, there is and will continue to be an acute shortage of health-service manpower. See--
Department of Survey Research, American Medical Association, Distribution of Physicians, Hospitals, and Hospital Beds in the U.S., Chicago, 1966.
W. H. Stewart and M. Y. Pennell, "Physicians' Age, Type of Practice and Location," Health Manpower Source Book, Section 10, U.S. Public Health Service, Washington, D.C., 1965.
Avedis Donabedian and S. J. Axelrod, op. cit.
William L. Kissick, "Health Manpower in Transition," Milbank Memorial Fund Quarterly, January 1968, pt. 2.

[22]Alonzo Yerby, op cit.
Mark Lepper, et al., op. cit.
Theodore McKeown, "Limitations in Medical Care Attributable to Medical Education," Lancet, February 1961.
Mark Lepper, "Health Planning for the Urban Community: The Neighborhood Health Center," (paper presented at) First National Congress on the Socio-Economics of Health Care, January 1967.

[23]Herbert Notkin, "Excellence in Public Welfare Medical Care," Public Welfare, July 1963.
Osler Peterson, "Quality and Quantity of Medical Care and Health," (paper presented at the annual meeting of the) American Sociological Association, 1962.

Irving K. Zola, "Problems of Communication, Diagnosis and Patient Care: The Interplay of Patient, Physician and Clinic Organization," Journal of Medical Education, October 1963.

[24]See footnotes 2 and 22.
Howard J. Brown, op. cit.

[25]Irwin Rosenstock, op. cit.

[26]Samuel Bloom, The Doctor and His Patient, A Sociological Interpertation, New York, Russell Sage Foundation, 1963.

[27]Avedis Donabedian and S. J. Axelrod, op. cit.

[28]Sol Levine and Paul E. White, "Exchange as a Conceptual Framework for the Study of Interorganizational Relationships," Administrative Science Quarterly, March 1961.

[29]Eugene Litwak, "Models of Bureaucracy Which Permit Conflict," American Journal of Sociology, September 1961.

[30]Some researchers, however, have argued for the superiority of neighborhood health centers. See--
Ruth Covell, "Delivery of Health Services for the Poor," Occasional Paper, Office of the Assistant Secretary for Program Planning and Evaluation, U.S. Department of Health, Education, and Welfare, Washington, D.C., 1967.
Mark Lepper, op. cit.
Researchers expressing other opinions include--
Lester Breslow, "New Partnerships in the Delivery of Services--A Public Health View of the Need," American Journal of Public Health, July 1967.
John D. Stoeckle and Irving K. Zola, "After Everyone Can Pay for Medical Care: Some Perspectives on Future Treatment and Practice," Medical Care, January-March 1964.

[31]E. Richard Weinerman and Herbert R. Edwards, "Yale Studies in Ambulatory Medical Care: I. Changing Patterns in Hospital Emergency Room Service," Hospitals, November 16, 1964.
Sidney Lee, et al., "How New Patterns of Medical Care Affect the Emergency Unit," Modern Hospital, May 1960.

[32]Mark Lepper, op. cit.
Alonzo Yerby, op. cit.

[33]See footnote 30.

[34]See footnote 21.

[35]Differences between the ideas of "fragmented care" and "episodic care" are explained in Jerry Solon, et al., "Delineating Episodes of Medical Care," American Journal of Public Health, March 1967. Cecil Sheps, M.D., former general director of the Beth Israel Medical Center, New York City, maintains that preventive care and the kind of pressure exerted by acute clinical activities as cited in Howard Brown are incompatible.

[36]We are indebted to Isadore Falk, Dean, School of Public Health, Yale University, for this thesis.

[37]See footnote 23.

[38]See footnote 22.

[39]Joseph C. Meyers, Jr., "Medical Care for Our Clients," Public Welfare, January 1965.
Thomas Brooks, "The Caseworker and the Client," New York Times Magazine, January 29, 1967.
Leona Baumgartner and James R. Dumpson, "Health in Welfare: A Joint or Divided Responsibility," Public Welfare, July 1962.

[40]Contributors to the Administrative Science Quarterly, a journal of theory and research on organizational subjects, represent all these fields.

[41]Most social organizational literature has centered almost entirely on the bureaucratic structure of the hospital. See--
Basil S. Georgopoulos and Floyd C. Mann, The Community General Hospital, New York and London, Macmillan, 1962.
Albert Wesson, "The Social Structure of a Modern Hospital," unpublished Ph.D. dissertation, University of Chicago, 1949.
Mary Goss, "Physicians in Bureaucracy, A Case Study of Professional Pressures on Organizational Roles," unpublished Ph.D. dissertation, Columbia University, 1959.
The few works about community efforts are--
Ivan Belknap and John G. Steinle, The Community and Its Hospitals: A Comparative Analysis, Syracuse, Syracuse University Press, 1963.
Eugene Litwak and Lydia Hylton, "Interorganizational Analysis," Administrative Science Quarterly, March 1962.
Sol Levine and Paul E. White, "The Community of Health Organizations," and Irwin Sanders, "Public Health in the Community," in Howard E. Freeman, et al., eds., Handbook of Medical Sociology, Englewood Cliffs, N.J., Prentice-Hall, Inc., 1963.

[42]James G. March, ed., Handbook of Organizations, Chicago, Rand McNally and Company, 1965.

[43]Sam Shapiro, et al., "Patterns of Medical Use by the Indigent Aged Under Two Systems of Medical Care," American Journal of Public Health, May 1967.

[44]Social and Rehabilitation Service (SRS) is supporting a comprehensive program of research on this aspect that will involve the Social Security Administration, U.S. Health Services and Mental Health Administration, Bureau of the

(Concluded on page 21)

Measuring the Potential of AFDC Families for Economic Independence

HAROLD A. MORSE

At the end of 1967, nearly 6,000 families in Denver were receiving payments through the Aid to Dependent Children program (AFDC).[1] [2] During the year some 2,500 cases were added to the caseload and more than 2,000 cases were closed. The costs of AFDC for the nearly 35,000 persons aided during the year totaled over $10 million. More than one out of 10 children in Denver is in a family receiving AFDC. Although there are AFDC families in every area of the city, the heaviest concentration is in the low-income areas dominated by Negroes, Mexican-Americans, and other minority groups. In some grade schools of the city, more than half of the children are from families aided by the AFDC program.

According to studies conducted by the Denver Department of Welfare, the AFDC parent, whether mother or father, generally is poorly educated and trained, marginal in work experience, and poorly equipped for self-support. AFDC parents are not strangers to poverty when they come to the welfare department; many have lived on the borderline of needing public assistance for a long time. Those among them who become self-supporting again have better schooling, greater job skill, and more work experience and are more competent in handling personal affairs and income than those who remain dependent. This is true regardless of race or ethnic background.

Development and Contents

Findings such as these led the Denver Department of Welfare to develop an inventory to measure the potential of AFDC families for economic independence. The inventory is made up of characteristics considered indicative of the status and level of the family's potential for economic independence. Under such headings as physical condition, mental condition, living arrangements, care of children, and management of income, the inventory lists 20 sets of descriptive terms for personal and family problems. These terms are arranged by the seriousness of the problems (based on empirical studies), that is, the degree to which they keep the family from being self-sufficient, and assigned a code number from zero to five for weighing. Five indicates the absence of problems concerning a given heading; zero, the most serious problems. The total score for a case is the sum of the scores for each item. Thus, for the 20 items used, the score could be from zero to 100.

The caseworker responsible for the case completes the inventory schedule after one or more home visits. He selects the term under each item that in his judg-

Mr. Morse is Supervisor, Research and Reports, Denver (Colo.) Department of Welfare.

Denver's Inventory is one of a number of projects conducted by State and local welfare agencies aimed at measuring the potential of AFDC families for economic independence. The Social and Rehabilitation Service is interested in various tested methods of approaching this objective but does not intend to suggest a particular method for Agency use. Articles like Mr. Morse's are in line with Welfare in Review's policy of acting as an exchange for information about experience with research-based projects and programs conducted by State and local welfare agencies.

ment best describes the situation of the parent or family (even though more than one might be applicable), and he enters his observations and judgments on a precoded schedule, guided by the schedule and a set of instructions and definitions. In a sense he follows the model of the census-taker, and he serves as a field staff member for the Research Unit of the Welfare Department. The Unit edits his entries for completeness and consistency. After the caseworker approves the editing, the coded entries are keypunched to the analysis card from the schedule. Additional information such as date and reason for closing the case are secured from departmental files and added to the analysis card.

The inventory score is predictive of prospects for the end of service under AFDC by employment--that is, because a parent obtains a job bringing in enough income to make the family economically independent--as illustrated in table 1 for a random sample of AFDC cases active in January 1964. Case status, active or closed, and reason for being closed were determined from departmental files as of August 1966--some 30 months after the caseworkers had made the evaluation. No provision was made for an evaluation of the cases by the caseworkers at that time.

The Welfare Department has applied the inventory to various samples of AFDC cases, including new and long-standing cases and cases from both the general and special caseloads. The prospects for closure and reopening of these cases has been checked annually. The findings from these studies are as follows:

1. A broad range of scores with a marked central tendency appears.
2. The scores are clearly related to the prospects for self-support, but not to reasons other than economic for closure.
3. The composite score is more highly associated with the prospects for self-support than any of its components.
4. The AFDC cases with above average inventory scores are more likely to be closed than those scoring below average.

Table 1. Closed AFDC cases as related to Denver's Inventory, August 1966

Inventory score	Number of cases			Reason for closing Percent		
	Total	Active	Closed	Total	Employment	Other
Total.....	595	414	181	30.4	10.8	19.6
Under 50..	53	37	16	30.2	1.9	28.3
50-54.....	71	52	19	26.8	5.6	21.2
55-59.....	110	88	22	20.0	6.4	13.6
60-64.....	162	109	53	32.7	10.5	22.2
65-69.....	126	85	41	32.5	12.7	19.8
70-74.....	55	35	20	36.4	21.8	14.6
75+	18	8	10	55.6	38.9	16.7

5. Cases that close tend to have higher inventory scores than cases remaining active.
6. Cases that do not reopen tend to have higher inventory scores than those that reopen.
7. Cases closed by employment tend to have higher scores than those closed for other reasons.
8. Reopened or reinstated cases do not materially differ in score from those that remain open.
9. Cases closed by employment are less likely to reopen for service under AFDC or to transfer to some other program of public support than those closed for other reasons.

Each finding represents a hypothesis regarding the AFDC caseload for the inventory of potential for economic independence. As they have been tested and sustained at the .05 level of confidence, it is unlikely that such results could have occurred by chance.

The Analytical Model

Based on the findings listed, an analytical model of AFDC caseloads can be constructed on the basis of this hypothesis: *the rate of closure of AFDC cases varies with the level of potential for economic independence as measured by the inventory but is constant at each level of potential no matter how long the case has been active.* Using this hypothesis the size of the AFDC caseload can be projected by applying the annual carryover rate, which varies by inventory score but is constant from year to year at each score level, to cases added during a given

year and to the cases carried over from year to year since the program began, assuming that the caseload is in equilibrium from year to year.

The model may be interpreted as actions taken on the total caseload during a given year, or it may be taken to represent actions on a group of cases approved in a given year over the time any of them remain on AFDC. Such a model is shown in table 2 for a monthly AFDC caseload of 4,000 cases with a one-third annual turnover. The annual caseload would total 6,000 cases and would include 4,000 carried over from the previous year and 2,000 cases added during the year. At the end of the year, the number of cases would still total 4,000 because 2,000 cases would have closed as reflected by the carryover rate.

The model indicates that after 10 years less than a hundred of the original 2,000 added during the first year would remain on AFDC. More than half of these residual cases would have scores under 50, and none of the original group with scores of 65 or more would remain active. The annual closure rates would decline with the length of time the cases had been open. Median scores would also show a decline for the residual cases with the length of time the cases had been open; and the average length of time on assistance would decrease as the inventory scores increase. On the average a case with a score of 75 or over would remain on AFDC for 13 months at a total cost of $2,200; a case with a score of less than 50 would remain on AFDC for an average of 69 months at a cost of nearly $14,000. These conclusions are derived from the model, not from actual caseload data; however, the model represents the actual caseload as projected from a random sample of 595 cases. Over a period of 2 years the sample data clearly conform to the patterns of the model and substantiate these expectations.

Critics of the AFDC program take the decreasing rate of closure with length of time on AFDC as proof that receipt of AFDC stifles motivation and creates "dependency." But no abstract idea such as "dependency" is necessary to explain why the longer a case has been on AFDC the less likely it is to be closed. The decreasing rate can be explained by the lower potential for economic independence

Table 2. Model of the annual AFDC caseload, based on annual rate of carryover related to inventory score

	Total	Inventory score						
		Under 50	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 +
Number of cases added[1]...	2,000	97	221	422	520	422	221	97
Annual carryover.....		85%	75%	65%	55%	45%	35%	25%
Number of cases carried over each year								
1st[2].....	1,527	88	191	344	397	301	147	59
2d.....	875	77	145	226	222	138	52	15
3d.....	527	65	109	147	122	62	18	4
4th.....	335	55	82	96	67	28	6	1
5th.....	223	47	62	62	37	13	2	0
6th.....	154	40	47	40	20	6	1	0
7th.....	109	34	35	26	11	3	0	0
8th.....	79	29	26	17	6	1	0	0
9th.....	59	25	20	11	3	0	0	0
10th.....	45	21	15	7	2	0	0	0
11th or more.....	67	34	21	10	2	0	0	0
Total number of cases..	6,000	612	974	1,408	1,409	974	447	176
Total number closed	2,000	97	221	422	520	422	221	97
Total number carried over.....	4,000	515	753	986	889	552	226	79

[1] Normal distribution of cases added to the AFDC caseload during the year.
[2] Rate of closure for cases added during the year would be only half the annual rate.

of the residual cases because of the selective closure process.

The model assumes no change in the potential for economic independence level while the case is on AFDC. As a result, the distribution of scores for closed cases, as predicted from the model, must be identical to that of cases added. The only difference would be that lower scoring cases would remain on assistance longer.

This feature of the model suggests that the net effect of AFDC social service programs can be measured by comparing the initial scores of cases added during a given year with the final score for cases closed during the same year--unless, of course, there have been major shifts in program contents or in economic conditions in the preceding 4 or 5 years.

Data indicate that the residual cases over time score better than the model would predict. Comparison of actual cases by initial and subsequent scores could indicate that the effect of social services is a net improvement in potential for economic independence while cases are in receipt of AFDC. Furthermore, the findings suggest that such improvement in ability to function competently for independence is just as pertinent for closure as the presence of such competency at the time of approval for the caseload.

Meaning for Service

In relating the inventory scores to the Federal "service areas" as identified by the caseworker for a sample of 314 new cases, the Research Unit obtained these findings:

1. Parenthood outside of wedlock occurs primarily among lower scoring cases.
2. The prospects for securing support from the absent father are greater among higher scoring cases.
3. The prospects for self-support are greater among the higher scoring cases.
4. Need for protection for children occurs primarily among the lowest scoring cases.
5. Special developmental problems among AFDC children are unrelated to the inventory score.

Among active AFDC cases, the concurrent receipt of child welfare services is more than twice as high for low-scoring cases as for high-scoring cases. Furthermore, families receiving child welfare services because of abuse or neglect, whether or not AFDC cases, score very low in comparison with the general AFDC caseload.

The measure of potential for economic independence takes the normal curve form for cases approved for the AFDC caseload and does not yield a clear-cut diagnostic typology. However, certain types of risks or prospects tend to stand out at different points of the distribution.

Cases scoring below 50 are clearly in need of protective or supportive services, since most of them usually score low for all aspects of social functioning. Although great improvement, at least for some aspects, does occur in some families, movement to the point of adequacy for self-support is rare for the low-scoring cases.

The families with scores above 70 appear to function adequately in most aspects and are able to respond effectively to such opportunities as education or work training programs. Their principal deficits with respect to adequacy for self-support lie in lack of education, job skill, and work experience, rather than in personal shortcomings.

The bulk of the AFDC caseload falls between 50 and 70 on the inventory score. On the one hand, these midrange cases tend to score high for "internalized values" such as social adjustment, care of children, care of the home, and management of income. On the other, they score low for those aspects requiring individual effort and commitment such as schooling and acquiring job skill and work experience. Apparently, training without extensive supportive and motivational efforts would not be particularly effective in helping them. Studies in Denver and elsewhere suggest that most movement to the level of adequacy for self-support will be

among cases near that level when they first receive AFDC.

Plans for Service

To become self-supporting, an AFDC family requires a fairly high degree of potential for economic independence. If families whose cases have been closed lack this potential, either reactivation or transfer to some other program is likely. Thus, self-support is the only practical service objective where the goal is to reduce welfare costs. The few months or years--an average of 27 months in Denver--the family is on AFDC offer an unusual opportunity for social rehabilitation and job training. As already pointed out, most of these families are disadvantaged before coming to AFDC. It would be a great waste not to use the time they are on AFDC to give them a boast to economic independence.

Data from Denver's Inventory indicate that ability to function adequately in respect to such aspects of personal and family life as physical and mental conditions, care of children, and management of the home is a prerequisite to effective use of training opportunities or job prospects. Studies in Denver and elsewhere suggest that intensive social services do help improve the ability of such families to function adequately. However, there are indications that such services must extend over several years if social functioning is to be adequate to the needs of hardcore families.

The inventory provides a basis for developing a cost-benefit formula for determining the resources that could be risked at various levels of potential for economic independence. For example, for the case scoring below 50 on the scale, an amount up to $7,500 could be spent for services and training if the length of time on AFDC could be reduced from an average of nearly 70 months to an average of only 35 months. However, such expenditures would be wasteful for cases already scoring at 70 or over because many of these could be expected to become self-supporting with minimum services.

The greatest value of a measure such as Denver's Inventory is the possibility of identifying the bulk of AFDC cases with marginal potential for economic independence and the greatest prospects for movement to the level of adequacy. Through such a method, the greatest return for services and training could be realized.

Administrative Plans

Virtually all information an agency has about its cases is recorded on forms or in narrative summaries in case records. The welfare director in a small county may know every family receiving AFDC through his department, and his caseworkers develop plans for each family based on personal knowledge of the family's situation. The welfare director in a large urban center, however, may not even recognize a single name on the voucher as he attests to the eligibility of a list of from five to ten thousand AFDC cases every month. Often, the knowledge of his caseworkers about the families they serve is limited to personal interviews and secondary information from such sources as public records. They often do not record crucial details and judgments. Because of frequent turnover in staff members, such information is often lost to a department until a new caseworker gets to know his cases.

The social work profession in general and administrators of welfare programs in particular have been hesitant, if not reluctant, to develop ideas and methods appropriate to objective evaluation, planning, and control of the administrative and service objectives of the agency. Yet in large urban areas the time is past when the welfare administrator can make plans around Miss A or Mr. and Mrs. B. He cannot assume responsibility for or be held accountable for each act of thousands of persons he may never see. He needs administrative methods that identify various high-risk groups or persons with certain prospects or potentials. Ideas such as the scaling of potential for economic independence and electronic com-

puter technology could make such administrative procedures available to him.

The current service goals in AFDC, for instance, emphasize concern for birth out of wedlock, protection of children, poor housekeeping, or misuse of income. Data available in Denver do not support the assumption that any sizable proportion of the caseload is affected by these problems, either singly or in combination. The fact is that virtually no welfare agency has baseline data concerning the incidence of such problems, much less current information on all its cases--at least not in a form that can be used to identify cases that might benefit from a particular service or that might represent a special type of risk.

At present when Head Start classes are to be filled, when MDTA (Manpower Development and Training Act) classes are to be scheduled, when an alcoholic clinic is to be opened, the welfare director must ask each caseworker to review his cases to identify those that could be referred. This means a great cost in staff time with no guarantee that every person or even those most in need will be considered. If the appropriate information were available on computers, say through an instrument such as Denver's Inventory, the applicable cases could be identified. The caseworkers might still be asked to do a personal evaluation for referral--however, there would be no need to review that 90 percent of the caseload for which the concern is not applicable.

A Final Word

This article has described a means of measuring potential for economic independence as a framework for the development of therapeutic and administrative plans for achieving the goals of AFDC and other welfare programs. It has suggested--that the linking of measurement methods from the social sciences with the capabilities of electronic computers would help the welfare administrator respond better to the needs and problems of large urban areas (where most welfare cases are concentrated).

Denver's Welfare Department has found that potential for economic independence can be measured to permit the development of an analytical model of the AFDC caseload[1] that can be used to clarify many of the questions arising about the program, from the standpoint of both the administrator and the community. The conclusions drawn here do not pertain to the question of whether more services, better trained staff members, or reduced caseloads would bring greater improvement to the general caseload under usual conditions. Such questions must be answered by controlled scientific experiments.

The crucial experiments for testing the value of social services cannot be conducted until the necessary measuring methods have been developed and tested. Before such methods can be developed, we must have a clearcut statement of program goals and a unified theory to explain and predict the way in which these goals are to be achieved. Only when the goals and the theories have been developed will measurement be possible, and only when such measuring methods are available will it be possible to evaluate the various remedial methods for both efficacy and cost.

The Denver Department of Welfare does not claim that the inventory at its present stage of development adequately meets the department's administrative needs for the evaluation and control of the service program or that it is now an adequate basis for form recording. Nor does the Department claim that the system would work equally well for other departments. It does claim, however, that some such method is necessary and its development and use inevitable.

---

[1] *Exclusive of the unemployed-parent segment.*

[2] *The program is still called ADC in Denver. AFDC is used here because it is the term in general use.*

[3] *Reweighting experiments show that the predictive ability of the Denver Inventory can be improved. A current version of the form is available from the Denver Department of Welfare (777 Cherokee Street, Denver, Colo. 80204).*

Public Opinion and Public Welfare

THE following notes are based on one chapter of the final report of an inquiry into the attitudes of the American public toward social security between 1935 and 1965, made under the Cooperative Research and Demonstration Grants Program by the National Opinion Research Center for the Social Security Administration. The final report, "Public Attitudes Toward Social Security, 1935-1965," was prepared by Michael Schiltz, formerly an associate of the Center, now executive vice president of the Institute of Urban Life in Chicago.

AMERICANS are bewildered by and ill-informed about welfare programs. A high level of generosity and a low level of self-interest characterize their attitudes toward public welfare programs, and they are torn between a high regard for personal industry and a low regard for what they consider to be wilful idleness.

These are among the major findings reported in a study of the attitudes of the American public toward social security over the last 30 years, conducted for the Social Security Administration by the National Opinion Research Center. The research analyzed data from 15 national polls conducted between 1935 and 1965, including data on specific questions related to social security and public welfare programs.

Other major findings concerning public opinion toward public welfare included these:

- When the term "needy" was used in survey questions, responses were uniformly more favorable than if terms such as "welfare program" were used. In the fall of 1961, during two surveys including questions about attitudes toward government spending, 60 percent of those interviewed said that the government should spend more money to help the "needy." But to questions about whether the government should spend tax money for "welfare programs," only about 30 percent said yes. Moreover a higher proportion of well-to-do than of low-income persons responded favorably to a tax increase to help the needy.
- Over the 30 years involved, a substantial proportion of the public attributed dishonesty to welfare recipients. For 1937 and 1939, for instance, roughly 60 percent of respondents said that public welfare recipients could get work if they tried. In 1960 almost the same proportion thought that "some" or "most" welfare recipients were receiving public welfare for dishonest reasons. In 1965 more than 80 percent of respondents thought that many people receiving unemployment benefits could have found work.
- Most people considered the "dole" as "inimicable to the American way of life," yet believed that the government must be responsible for the poor. A 1964 survey found that 64 percent of those interviewed said that "welfare" and "relief" make people lazy; 75 percent agreed that the government must be responsible for the poor.
- Differences in attitudes were not substantially related to differences in age, income, education, and occupation. (Data did not permit the comparison of attitudes held by white persons and Negroes.)

Using survey data to analyze public attitudes toward welfare presents many problems, the researchers found. Because of unclear questions, imprecise terms, noncomparability of surveys, and different methods of classifying and tabulating responses, the final report points out that it is not possible from the data to draw inferences about the public's attitude over the period 1935-65 toward welfare and that the measurement of public opinion about any public program requires a complex battery of questions, answers to any one of which may suggest distorted conclusions. The report also points out that these questions are crucial to the issue of public opinion toward public welfare because the Nation "appears to be entering a period of fundamental reassessment of its welfare program in which questions of public acceptability are central."

BOOK NOTE

The ITPA Test

Interpretation of the 1961 Illinois Test of Psycholinguistic Abilities (With Reproductions of Original Profiles). Barbara D. Bateman. Special Child Publications, Seattle, Wash. 1968. $3.

THE 1961 Experimental Edition of the Illinois Test of Psycholingustic Abilities (ITPA) has been widely adopted throughout the country, a fact testifying to the urgent need for a comprehensive diagnostic test for the language development of exceptional young children. However, partly due to the test's complexity and the tentative state of knowledge on the development of psycholinguistic abilities, difficulties are posed for the test administrator in scoring and evaluating the test results. Dr. Bateman has distilled the benefits of her considerable clinical and research experience with the test and presents in this monograph a brief but informative crystallization of a number of the critical problems and considerations in its administration, evaluation, and interpretation. Her work should serve as a useful supplement to the test manual and as a starting-off point for persons interested in a more detailed followup of particular problems.

The first chapter in the monograph covers each of the nine subtests of the ITPA and briefly reviews the test's measurement goals and data on its empirical validity. It contains discussion concerning problems and questions that have been presented in practice. The flavor of the treatment is imparted, for example, in the discussion on the vocal encoding subtest used to measure a child's ability to verbally present meaningful ideas in response to a simple visual stimulus. Dr. Bateman advises: "Disregard the one-minute guideline suggested in the manual. This has been misleading with clinical cases, presumably because it was derived from experience with the 'normal' standardization population. The experienced examiner will obtain more appropriate clues as to when the responses are exhausted from the child than from a watch."

Subsequent chapters deal with profiles of exceptional groups of children, the ITPA and reading prediction, interpretation of individual profiles, and handling ITPA data for comparisons between individual children. This information can be accepted as suggestions providing rough guidelines.

One of Dr. Bateman's most interesting discussions deals with the "Strauss Syndrome" profile in which a child displays visual-perceptual problems, hyperactivity, and the like. Dr. Bateman comments that "one extremely important caution must be heeded in looking at a Strauss Syndrome profile. It is identical in shape to that shown by the highly intelligent, very verbal child from achievement-oriented, upper middle class suburbia." In one school in an affluent area, well over half the kindergarten children showed this pattern. The crucial difference, she says, lies in the relation of the profile level to the child's chronological age. The child with the Strauss Syndrome scores much lower in general than the verbal middle class child.

This monograph should serve the test administrator as a useful information supplement to the 1961 test manual and as a brief survey of the present formative state of knowledge concerning the test, its significance, usefulness, and limitations. By its very intention of providing a guide to all potential users of the test, the treatment is extensive rather than intensive. To the test administrator who wants a final answer to the meaning of test results, it will be disappointing. Such answers await the accumulation of more data and clinical experience, as well as greater understanding of the structure and development of psycholinguistic abilities.

ARTHUR ALTERMAN
Research Specialist
Intramural Research Division
Social and Rehabilitation Service

The Health-Care System

(Concluded from page 12)

Budget, and Office of Economic Opportunity, as well as SRS.

[45]Sol Levine and Paul E. White, "The Community of Health Organizations," in Howard E. Freeman, et al., eds., Handbook of Medical Sociology, Englewood Cliffs, N.J., Prentice-Hall, Inc., 1963.

[46]Eugene Litwak, op. cit.

[47]W. Richard Scott, "Theory of Organizations," in R.E.L. Faris, ed., Handbook of Sociology, Chicago, Rand McNally, 1964.

[48]Such questions have been raised by staff members of the Office of the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health, Education, and Welfare, and priorities have been tentatively identified, sometimes necessarily based on less than fully and adequately verified data.

[49]For a comprehensive guide to Federal aid for health-care programs see To Improve Medical Care, U.S. Department of Health, Education, and Welfare, April 1966.

For a discussion of the meaning of recent legislation concerning health care for the poor see Ellen Winston, "Health-Welfare Partnership in Programs for Low-Income Groups," American Journal of Public Health, July 1967.

New Publications

Publications for which prices are listed may be ordered from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 (25 percent discount on orders of 100 or more). Payment must accompany order. Single copies of publications for which no prices are listed are available from the issuing agency.

Social and Rehabilitation Service

Good camping for children and youth of low income families, by Catherine V. Richards. Children's Bureau, 1968, 21 pp.

Poor people at work: an annotated bibliography on semi-professionals in education, health, and welfare services, by Linda I. Millman and Catherine S. Chilman. Intramural Research Division, Office of Research, Demonstrations, and Training, 1968, 40 pp.

The role of organized labor in the vocational training and placement of hard-core youth. Office of Juvenile Delinquency and Youth Development, 1968, 102 pp.

Other Government

Employment during pregnancy, legitimate live births: United States, 1963. National Center for Health Statistics, Department of Health, Education, and Welfare. Public Health Service Publication No. 1000-Series 22-No. 7. U.S. Government Printing Office, 1968, 300 pp., 35 cents.

The school of social work's responsibilities in family planning education, by Katherine B. Oettinger. Department of Health, Education, and Welfare, 1968, 16 pp.

Statistics on public institutions for delinquent children, 1966, by Louise F. Jackson and Daisy C. Ligons. Children's Bureau, 1967, 58 pp. (CB statistical series, 89).

Non-Government

Inquiries and orders should be directed to the publisher or issuing agency.

Children, poverty, and family allowances, by James C. Vadkin. Basic Books, 404 Park Ave. South, New York, N.Y. 10016. 1968, 222 pp., $6.50.

Communication and social change in Latin America: introducing new technology, by Paul J. Deutschmann and others. Praeger, 111 Fourth Ave., New York, N.Y. 10003. 1968, 123 pp., $10.

Consumer responses to income increases, by George Katona and Eva Mueller. Brookings Institution, 1775 Massachusetts Ave., NW., Washington, D.C. 20036. 1968, 244 pp., $6.75.

Day care aides: a guide for in-service training, Mary Watson Palmer, ed. National Federation of Settlements and Neighborhood Centers, 232 Madison Ave., New York, N.Y. 10016. 1968, 114 pp., $2. (A handbook for training nonprofessionals. See also *Selected readings for trainees for day care aides*, below.)

Delinquents and nondelinquents in perspective, by

Sheldon and Eleanor Glueck. Harvard University Press, 79 Garden Street, Cambridge, Mass. 02138. 1968, 268 pp., $8.50. (Includes data from *Unraveling juvenile delinquency*, published in 1950, and adds new data.)

Differential use of manpower: a team model for foster care. Child Welfare League of America, 44 E. 23d St., New York, N.Y. 10010. 1968, 49 pp., $1.60. (Six papers by Donald Brieland and others.)

Economic planning and policies in Britain, France and Germany, by Geoffrey Denton and others. Allen and Unwin (publishers), London. 1968, 424 pp., about $6.

Employing the minority group college graduate: recruiting, evaluating qualifications, retaining employees, by Robert Calvert, Jr. The Garrett Park Press, Garrett Park, Md. 20766. 1968, $3.

Employment of the poor as preprofessionals, by John E. Hiland, Jr. American Public Welfare Association, Technical Assistance Project, 1545 E. 60th St., Chicago, Ill. 60637. 1968, 16 pp., single copies free. (Supplement No. 5, *Public Welfare--Challenge to Validity.)*

The field of social work, by Arthur E. Fink, C. Wilson Anderson, and Merrill B. Conover, 5th ed. Holt, Rinehart, and Winston, 383 Madison Ave., New York, N.Y. 10017. 1968, 534 pp., $7.95.

Four years old in an urban community, by John and Elizabeth Newson. Aldine Publishing Co., 320 W. Adams St., Chicago, 60606. 1968, 578 pp., $12.50.

The improvement of mankind: the social and political thought of John Stuart Mill, by John M. Robson. University of Toronto Press, Toronto. 1968, 292 pp., $6.50.

Medicaid: state programs after two years. Tax Foundation, Inc., 50 Rockefeller Plaza, New York, N.Y. 10020. 1968, 72 pp., $1.50. (Research publication No. 15, new series.)

Politics and policy: the Eisenhower, Kennedy, and Johnson years, by James L. Sundquist. Brookings Institution, 1775 Massachusetts Ave., NW., Washington, D.C. 20036. 1968, 560 pp., $8.75.

The protective services center, by G. Lewis Penner, with a critique by Henry H. Welch. Children's Division, American Humane Association, P.O. Box 1266, Denver, Colo. 80201. (Describes the Louise deKoven Bowen Center in Chicago which provides both protective casework and auxiliary supportive services.)

Selected readings for trainees for day care aides, Mary Watson Palmer, ed. National Federation of Settlements and Neighborhood Centers, 232 Madison Ave., New York, N.Y. 10016. 1968, 98 pp., $1.25. (Excerpts from *Day care aides*, listed above, designed for use by trainees.)

Social welfare in the Soviet Union, by Bernice Q. Madison. Stanford University Press, Stanford, Calif. 94305. 1968, 298 pp., $8.50. (Services include family and child welfare, services for delinquent youth, money grants and assistance in kind, vocational rehabilitation, and services for the aged.)

Studies in economic stabilization, Albert Ando and others, eds. Brookings Institution, 1775 Massachusetts Ave., NW., Washington, D.C. 20036. 1968, 299 pp., $6.75.

World population: an analysis of vital data, by Nathan Keyfitz and Wilhelm Flieger. University of Chicago Press, 5750 Ellis Ave., Chicago, Ill. 60637. 1968, 672 pp., $16.50.

Program and Operating Statistics

Public Assistance in June and July 1968

June

The total number of persons receiving maintenance payments under the public assistance programs decreased for the third successive month. The June decrease of 18,000 brought the total during the 3-month period down to 45,000. The factor contributing most to the decrease in number of recipients in June was the reduction of 36,000 in the unemployed-father segment of aid to families with dependent children. Other decreases in the numbers of persons aided amounted to 12,000 in general assistance, 3,000 in old-age assistance, and less than 100 in aid to the blind. In aid to families with dependent children, exclusive of the unemployed-father segment, there was an increase of 30,000 recipients--the smallest monthly rise in 11 months. About 4,000 more persons received aid to the permanently and totally disabled in June than in May.

Total expenditures for assistance, including vendor payments for medical care, were $815.4 million in June--$17.8 million above the May total. Increases in the medical assistance programs in California ($11.4 million) and Michigan ($4.9 million) accounted for most of the rise.

Total money payments continued to rise; the increase of $4.9 million reflected mainly an increase of $4.6 million in aid to families with dependent children. Under this program New York reported that money payments rose by $3.3 million, largely because of the inclusion in June payments of extra amounts for the replacement of clothing and household equipment. Puerto Rico reported an increase of $1.9 million because of payment of a higher percentage of determined need and inclusion in June payments of amounts covering the increase retroactively for April and May. In aid to the permanently and totally disabled total money payments increased by $499,000. There were slight increases in payments for old-age assistance and aid to the blind--$95,000 and $13,000 respectively.

In Puerto Rico upward adjustments in payments similar to that for aid to families with dependent children were also put into effect for the other federally aided programs. As a result, the average payment per recipient rose more than $10 in each program. In Colorado living cost adjustments in assistance standards were responsible for increases in the average per recipient of $6 in aid to the blind, $4 in aid to the permanently and totally disabled, and $2 in aid to families with dependent children.

Table 1. Amount of public assistance payments in the United States, by month, June 1967-June 1968[1]

Year and month	Total	Money payments 2/							Medical vendor payments 3/					
		Total	Federally aided programs					General assistance 5/	Total	Federally aided programs				General assistance 5/
			Total	Old-age assistance 4/	Aid to the blind 4/	Aid to the permanently and totally disabled 4/	Aid to families with dependent children			Total	Medical assistance 6/	Medical assistance for the aged 4/	Other	
	Amount of assistance (In thousands)													
1967														
June	$634,610	$405,494	$379,649	$140,563	$7,255	$47,254	$184,577	$25,845	$229,116	$224,042	$196,066	$4,649	$23,327	$5,074
July	629,482	408,221	382,390	141,668	7,295	47,951	185,476	25,831	221,261	216,933	190,184	6,472	20,277	4,328
August	678,341	416,861	389,058	142,132	7,348	49,057	190,521	27,803	261,480	256,332	231,053	5,023	20,256	5,148
September	672,973	423,302	394,979	141,645	7,365	49,610	196,359	28,323	249,671	244,926	223,515	5,173	16,238	4,745
October	705,942	432,664	403,477	143,640	7,400	50,576	201,861	29,187	273,278	269,134	249,788	5,013	14,333	4,143
November	717,664	436,611	407,068	144,588	7,406	51,125	203,949	29,543	281,053	276,471	258,164	5,151	13,156	4,579
December	713,589	445,526	414,690	145,425	7,475	52,054	209,736	30,836	268,063	263,375	244,875	4,920	13,580	4,688
1968														
January	760,705	454,739	422,104	145,603	7,505	52,689	216,307	32,635	305,966	301,891	282,708	5,508	13,675	4,075
February	742,761	455,226	423,011	144,748	7,436	52,828	217,999	32,215	287,535	282,535	263,231	5,460	13,844	5,001
March	774,466	455,621	422,857	140,385	7,374	52,696	222,402	32,764	318,845	314,704	295,153	5,388	14,163	4,139
April	844,112	457,290	424,484	136,733	7,345	53,313	227,093	32,806	386,822	381,691	362,049	5,332	14,310	5,131
May	797,684	461,177	427,896	136,661	7,375	53,802	230,058	33,281	336,507	331,456	311,170	5,675	14,611	5,051
June	815,439	466,048	433,121	136,756	7,388	54,301	234,676	32,927	349,391	344,624	324,343	5,480	14,801	4,767
	Percentage change from preceding month													
1967														
June	+1.4	+0.5	+0.5	-0.2	0	+1.2	+0.8	+0.6	+3.1	+3.5	+4.2	-7.4	+0.3	-0.8
July	-.8	+.7	+.7	+.8	+.5	+1.5	+.5	-.1	-3.4	-3.2	-3.0	+39.2	-13.1	-14.7
August	+7.8	+2.1	+1.7	+.3	+.7	+2.3	+2.7	+7.6	+18.2	+18.2	+21.5	-22.4	-.1	+18.9
September	-.8	+1.5	+1.5	-.3	+.2	+1.1	+3.1	+1.9	-4.5	-4.4	-3.3	+3.0	-19.8	-7.8
October	+4.9	+2.2	+2.2	+1.4	+.5	+1.9	+2.8	+3.0	+9.5	+9.9	+11.8	-3.1	-11.7	-12.7
November	+1.7	+.9	+.9	+.7	+.1	+1.1	+1.0	+1.2	+2.8	+2.7	+3.4	+2.8	-8.2	+10.5
December	-.6	+2.0	+1.9	+.6	+.9	+1.8	+2.8	+4.4	-4.6	-4.7	-5.1	-4.5	+3.2	+2.4
1968														
January	+6.6	+2.1	+1.8	+.1	+.4	+1.2	+3.1	+5.8	+14.1	+14.6	+15.4	+12.0	+.7	-13.1
February	-2.4	+.1	+.2	-.6	-.9	+.3	+.8	-1.3	-6.0	-6.4	-6.9	-.9	+1.2	+22.7
March	+4.3	+.1	(7/)	-3.0	-.8	-.3	+2.0	+1.7	+10.9	+11.4	+12.1	-1.3	+2.3	-17.2
April	+9.0	+.4	+.4	-2.6	-.4	+1.2	+2.1	+.1	+21.3	+21.3	+22.7	-1.0	+1.0	+24.0
May	-5.5	+.8	+.8	-.1	+.4	+.9	+1.3	+1.4	-13.0	-13.2	-14.1	+6.4	+2.1	-1.6
June	+2.2	+1.1	+1.2	+.1	+.2	+.9	+2.0	-1.1	+3.8	+4.0	+4.2	-3.4	+1.3	-5.6
	Percentage change from same month of preceding year													
1968														
June	+28.5	+14.9	+14.1	-2.7	+1.8	+14.9	+27.1	+27.5	+52.5	+53.8	+65.4	+17.9	-36.6	-6.1

1/ All data subject to revision.
2/ Includes nonmedical vendor payments.
3/ Amounts represent primarily bills paid during the month and therefore are subject to fluctuations unrelated to provisions of medical services.
4/ Represents data for recipients of the specified types of assistance under separate State programs and under State programs for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged.
5/ Partly estimated. Does not include Idaho, Indiana, Kentucky, Nebraska, and Puerto Rico for all months, and Nevada beginning January 1968; data not available. Percentage changes based on comparable data.
6/ Data incomplete.
7/ Decrease of less than 0.05 percent.

Table 2. Number of recipients of public assistance money payments in the United States, by month, June 1967-June 1968[1]

Table 2. Number of recipients of public assistance money payments in the United States, by month, June 1967-June 1968[1]

Year and month	Federally aided programs								General assistance 2/	
	Total	Adult programs				Aid to families with dependent children				
		Total	Old-age assistance 3/	Aid to the blind 3/	Aid to the permanently and totally disabled 3/	Families	Total recipients 4/	Children	Cases	Recipients
	Number of recipients (In thousands)									
1967										
June	7,740	2,763	2,065	83.0	615	1,208	4,977	3,744	311	664
July	7,742	2,764	2,062	82.8	618	1,212	4,978	3,745	313	678
August	7,834	2,776	2,068	82.9	625	1,232	5,058	3,802	332	726
September	7,879	2,777	2,065	82.8	629	1,244	5,102	3,838	333	729
October	7,937	2,788	2,070	82.8	636	1,258	5,148	3,871	335	735
November	8,004	2,797	2,074	82.8	640	1,273	5,207	3,907	342	758
December	8,111	2,802	2,073	82.7	646	1,297	5,309	3,986	352	782
1968										
January	8,238	2,804	2,070	82.5	651	1,327	5,442	4,080	365	817
February	8,316	2,796	2,060	82.3	654	1,346	5,520	4,132	363	798
March	8,369	2,782	2,044	81.7	656	1,365	5,587	4,180	365	792
April	8,381	2,769	2,028	81.4	660	1,374	5,612	4,203	360	762
May	8,385	2,770	2,023	81.2	666	1,380	5,615	4,209	358	749
June	8,379	2,770	2,019	81.2	670	1,383	5,609	4,207	356	737
	Percentage change from preceding month									
1967										
June	+0.1	+0.1	(5/)	-0.1	+0.9	+0.5	+0.1	+0.1	-1.2	-1.7
July	(6/)	(6/)	-.1	-.2	+.6	+.3	(6/)	+.1	+.7	+2.2
August	+1.2	+.4	+.3	+.1	+1.1	+1.7	+1.6	+1.5	+6.2	+7.0
September	+.6	(6/)	-.1	-.2	+.7	+1.0	+.9	+.9	+.4	+.5
October	+.7	+.4	+.2	0	+1.0	+1.1	+.9	+.9	+.7	+.8
November	+.8	+.3	+.2	0	+.7	+1.2	+1.1	+.9	+1.9	+3.1
December	+1.3	+.2	-.1	-.2	+.8	+1.9	+2.0	+2.0	+3.0	+3.2
1968										
January	+1.6	+.1	-.1	-.2	+.7	+2.2	+2.4	+2.2	+3.7	+4.5
February	+.9	-.3	-.5	-.3	+.6	+1.5	+1.6	+1.4	-.3	-2.3
March	+.6	-.5	-.8	-.8	+.4	+1.4	+1.2	+1.2	+.6	-.7
April	+.1	-.5	-.8	-.4	+.5	+.7	+.4	+.5	-1.5	-3.8
May	(6/)	(6/)	-.3	-.2	+.9	+.4	+.1	+.1	-.3	-1.7
June	-.1	0	-.2	0	+.6	+.2	-.1	(5/)	-.8	-1.6
	Percentage change from same month of preceding year									
1968										
June	+8.3	+.3	-2.2	-2.2	+9.0	+14.5	+12.7	+12.4	+14.4	+10.7

1/ All data subject to revision.
2/ Partly estimated. Does not include Idaho, Indiana, Kentucky, Nebraska, and Puerto Rico for all months, and Nevada beginning January 1968; data not available. Percentage changes based on comparable data.
3/ Represents data for recipients of the specified types of assistance under separate State programs and under State programs for the aged, blind, or disabled, or for such aid and medical assistance for the aged.
4/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance.
5/ Decrease of less than 0.05 percent.
6/ Increase of less than 0.05 percent.

Table 3. Old-age assistance: Recipients and payments to recipients, by State, June 1968[1]

/Excludes vendor payments for medical care and cases receiving only such payments/

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	May 1968 in--		June 1967 in--	
				Number	Amount	Number	Amount
Total 2/....	2,019,000	$136,756,000	$67.70	-0.2	+0.1	-2.2	-2.7
Ala.....	113,000	6,678,000	59.35	-.1	(3/)	-.6	-2.1
Alaska 4/.....	1,500	117,000	80.25	0	+1.1	+4.8	+18.9
Ariz.....	12,900	650,000	50.50	+6.0	-.2	-.5	-11.4
Ark. 4/.....	62,000	3,397,000	54.75	-.3	-.4	-3.5	-11.7
Calif.....	292,000	29,146,000	99.85	+.5	+.7	+1.0	-.8
Colo. 2/.....	39,000	3,022,000	77.50	-.5	-.7	-4.9	-7.9
Conn.....	6,900	497,000	72.25	-6.6	-12.3	+11.7	+14.9
Del.....	1,800	116,000	62.85	+1.9	+8.8	+6.4	+4.6
D. C.....	2,200	169,000	74.95	+1.3	+1.5	-.4	+6.8
Fla. 4/	70,800	3,323,000	46.95	-.3	-.1	-9.8	-14.5
Ga. 4/.....	88,500	4,596,000	51.90	(5/)	(5/)	-6.2	+3.2
Guam 6/.....	240	12,600	52.10	---	---	---	---
Hawaii 4/.....	1,900	152,000	81.95	+.2	+.7	+7.7	+12.9
Idaho.....	3,500	222,000	63.85	-1.2	-.6	-8.4	-12.0
Ill. 4/.....	37,900	2,280,000	60.20	-.4	-5.5	-2.8	-2.9
Ind.....	17,700	827,000	46.70	-.6	-.4	-8.7	-7.8
Iowa.....	23,600	2,390,000	101.45	-.4	-.2	-1.7	+63.5
Kans. 4/	16,200	1,421,000	87.50	-.5	-.8	-6.2	-.9
Ky. 4/.....	60,800	3,255,000	53.50	+.1	-.2	+1.7	-2.5
La.....	122,000	8,539,000	69.85	-.2	-.3	-1.7	-6.1
Maine 4/.....	10,100	542,000	53.75	-.3	+.1	-1.2	-2.8
Md. 4/.....	7,700	462,000	59.95	-.3	(3/)	-2.0	-2.5
Mass.....	48,000	3,863,000	80.45	-.3	+.5	-3.2	-2.5
Mich.....	38,000	2,548,000	67.05	-.6	-.7	-4.3	-5.9
Minn.....	24,100	1,512,000	62.70	-.6	(3/)	-8.6	-5.1
Miss.....	71,400	2,571,000	36.05	-.2	-.4	-4.7	-12.3
Mo.....	91,800	6,229,000	67.85	-.2	+.1	+2.9	+2.2
Mont.....	3,700	236,000	64.00	-.8	-.9	-5.5	-4.1
Nebr. 4/.....	8,300	474,000	56.80	-.5	-.6	-10.5	-5.5
Nev.....	2,600	191,000	74.70	-.9	-.8	+3.5	+3.0
N. H.....	4,100	444,000	107.70	-.4	(3/)	-1.2	+7.7
N. J.....	14,000	1,018,000	72.65	-.1	+.1	+2.4	-.8
N. Mex. 4/.....	9,600	518,000	54.20	+.3	(5/)	+.1	-5.7
N. Y. 4/.....	76,100	7,041,000	92.50	+.4	-.3	+10.0	+20.5
N. C.....	37,400	2,455,000	65.70	(3/)	+2.0	-5.3	+2.3
N. Dak. 4/.....	4,100	307,000	74.85	-.5	+.3	-5.7	-8.7
Ohio.....	61,500	3,741,000	60.85	-.6	-.7	-14.0	-32.9
Okla. 4/.....	77,500	5,555,000	71.65	-.3	-.4	-3.6	-7.4
Oreg.....	8,800	508,000	57.70	-.5	-.1	-20.5	-10.4
Pa.....	42,800	3,019,000	70.60	-.2	+.1	-2.3	-7.8
P. R. 4/.....	22,000	444,000	20.15	-.7	+111.3	-9.3	+108.0
R. I. 4/.....	4,100	245,000	59.10	-.8	-.9	-8.3	-5.0
S. C.....	20,100	933,000	46.35	-6.6	-1.5	-8.4	+2.7
S. Dak.....	4,900	304,000	61.65	-1.0	-.9	-10.8	-12.3
Tenn.....	50,100	2,472,000	49.30	+.4	+.2	+7.6	-.3
Tex.....	229,000	13,803,000	60.25	-.1	-.1	(5/)	-2.7
Utah.....	4,100	222,000	54.15	-.9	-1.1	-10.2	-19.0
Vt. 4/.....	4,300	290,000	67.95	+.4	+.7	+.9	+4.7
V. I.....	370	14,300	38.70	-1.6	-.8	-7.5	-6.4
Va.....	10,800	606,000	55.85	-.1	+1.1	-1.6	+.6
Wash.....	24,300	1,513,000	62.40	-1.1	-1.3	-8.0	-14.8
W. Va.....	11,300	695,000	61.60	-.2	+.8	-5.8	+3.6
Wis.....	16,300	1,014,000	62.25	-.3	(3/)	-5.7	+1.5
Wyo.....	2,100	162,000	78.00	-.2	+1.0	-8.8	+.8

1/ All data subject to revision.
2/ Includes 3,700 recipients aged 60-64 in Colorado and payments of $331,000 to these recipients. Such payments were made without Federal participation.
3/ Decrease of less than 0.05 percent.
4/ Represents aid to the aged under program for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged.
5/ Increase of less than 0.05 percent.
6/ Data for May; June data not reported.

Table 4. Aid to the blind: Recipients and payments to recipients, by State, June 1968[1]

[Excludes vendor payments for medical care and cases receiving only such payments]

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	May 1968 in--		June 1967 in--	
				Number	Amount	Number	Amount
Total 2/ 3/	81,200	$7,388,000	$91.05	-0.1	+0.2	-2.2	+1.8
Ala.	1,900	131,000	70.15	+.5	+.6	+1.8	+1.7
Alaska 4/	94	10,200	108.65	(5/)	(5/)	(5/)	(5/)
Ariz.	650	45,800	70.20	+.3	+.6	-9.8	-10.0
Ark. 4/	1,800	128,000	69.40	-.4	-.3	-4.1	-6.4
Calif. 2/	12,500	1,731,000	138.25	+.2	+.4	+.8	+5.2
Colo.	200	14,800	72.05	+1.0	+10.3	-4.2	-5.1
Conn.	240	20,100	82.25	-2.4	-2.7	-7.2	-6.4
Del.	340	31,200	91.35	+.6	+6.1	+1.8	+10.6
D. C.	180	16,300	89.60	+.6	+1.4	-7.6	-.1
Fla. 4/	2,400	152,000	62.55	-.2	-.1	-5.7	-6.4
Ga. 4/	3,200	198,000	62.90	+.1	(6/)	(7/)	+9.8
Guam 8/	6	290	(5/)	---	---	---	---
Hawaii 4/	72	7,100	99.20	(5/)	(5/)	(5/)	(5/)
Idaho	100	7,900	76.75	-2.8	-2.6	-3.7	-10.4
Ill. 4/	1,800	144,000	80.25	-.7	-3.7	-6.0	-.4
Ind.	1,400	93,800	65.05	-.1	-6.2	-7.9	-5.8
Iowa	1,000	111,000	106.20	+.3	-.6	-.8	+12.6
Kans. 4/	390	35,200	89.20	+.8	-2.2	-3.4	-2.2
Ky. 4/	2,600	184,000	70.50	-.1	(6/)	+3.6	+4.4
La.	2,500	191,000	77.05	-.6	+.4	-1.7	-.7
Maine 4/	210	15,900	75.15	-1.9	+.6	-5.8	-3.6
Md. 4/	350	28,400	82.05	-.6	-1.8	+2.7	+11.6
Mass.	2,500	306,000	123.90	+1.0	-1.0	+7.9	+14.7
Mich.	1,400	126,000	87.90	-.1	+.7	-2.5	+2.2
Minn.	800	64,400	80.20	-.6	-.3	-4.1	-.8
Miss.	2,300	105,000	45.25	-.2	+.8	-6.3	-9.1
Mo. 2/	3,900	338,000	86.85	+.7	+.9	-2.3	+6.1
Mont.	160	12,500	79.50	-6.5	-2.2	-7.1	-7.2
Nebr. 4/	350	29,900	84.60	0	+1.3	-11.1	+4.5
Nev.	150	15,300	100.50	-1.3	+3.1	-.7	+12.7
N. H.	240	25,600	108.60	0	-1.7	-4.1	+.3
N. J.	880	77,700	87.80	0	-.9	-1.3	-4.9
N. Mex. 4/	370	27,800	75.20	+1.4	+1.1	+4.8	+7.1
N. Y. 4/	3,200	389,000	120.20	-1.0	+2.5	+2.5	+19.7
N. C.	4,600	364,000	78.85	+.3	+2.0	-.8	+5.0
N. Dak. 4/	82	6,700	81.85	(5/)	(5/)	(5/)	(5/)
Ohio	2,800	206,000	72.70	+.5	+.1	-4.5	-9.2
Okla. 4/	1,500	156,000	104.30	+1.1	+1.2	-3.4	-3.8
Oreg.	500	45,000	89.50	-1.4	-.1	-1.0	+1.0
Pa. 3/	9,300	1,002,000	107.45	-.1	-.3	-5.8	-6.4
P. R. 4/	800	16,200	20.10	-1.0	+106.8	-28.4	+68.7
R. I. 4/	110	8,200	71.40	-1.7	-5.3	+1.8	+1.7
S. C.	1,900	111,000	59.05	-2.1	-.3	+.4	+7.3
S. Dak.	110	9,600	85.75	-2.6	-.6	-1.8	+2.6
Tenn.	1,800	121,000	67.35	-.2	-.1	-2.2	-2.0
Tex.	4,200	305,000	72.70	(7/)	-.3	-.4	-3.3
Utah	140	8,200	60.20	-4.2	-6.9	-3.5	-12.3
Vt. 4/	100	9,000	85.90	0	+.2	+3.7	+12.9
V. I.	9	380	(5/)	(5/)	(5/)	(5/)	(5/)
Va.	1,100	80,000	73.90	-.1	-2.1	-1.7	+.1
Wash.	480	42,000	87.30	-1.4	-1.2	-6.6	-3.7
W. Va.	600	34,100	56.55	+.3	+.1	-6.7	-.9
Wis.	570	45,200	78.75	-.7	-5.4	-6.7	-.2
Wyo.	43	3,200	(5/)	(5/)	(5/)	(5/)	(5/)

1/ All data subject to revision.
2/ Data include recipients of payments made without Federal participation and payments to these recipients as follows: California, $29,600 to 170 recipients and Missouri, $61,900 to 700 recipients.
3/ Does not include $580,000 to an estimated 7,800 recipients under State blind pension program in Pennsylvania administered under State Law without Federal participation.
4/ Represents aid to the blind under program for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged.
5/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients.
6/ Decrease of less than 0.05 percent.
7/ Increase of less than 0.05 percent.
8/ Data for May; June data not reported.

Table 5. Aid to the permanently and totally disabled: Recipients and payments to recipients, by State, June 1968[1]

/Excludes vendor payments for medical care and cases receiving only such payments/

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	May 1968 in--		June 1967 in--	
				Number	Amount	Number	Amount
Total.....	670,000	$54,301,000	$81.10	+0.6	+0.9	+9.0	+14.9
Ala.....	15,700	781,000	49.65	+.5	+.4	+3.4	+13.2
Alaska 2/.....	460	46,900	101.80	0	+1.4	+33.2	+75.7
Ariz.....	6,100	400,000	65.70	+.6	+.6	+13.0	+12.2
Ark. 2/.....	11,400	704,000	61.60	+.1	-.2	+1.9	-2.1
Calif.....	125,000	14,663,000	117.55	+.8	+.7	+15.0	+16.5
Colo.....	7,200	481,000	67.15	+.7	+7.0	+3.4	+6.8
Conn.....	4,900	454,000	92.70	-5.0	-8.8	-7.2	+2.5
Del.....	1,100	100,000	91.50	+2.5	+3.5	+34.8	+32.5
D. C.....	4,200	379,000	89.60	(3/)	+1.8	+2.3	+9.9
Fla. 2/.....	20,300	1,210,000	59.45	(3/)	+.1	-2.8	-4.1
Ga. 2/.....	29,400	1,806,000	61.35	+.3	+.2	+4.1	+14.9
Guam 4/.....	50	2,900	57.90	---	---	---	---
Hawaii 2/.....	1,600	169,000	108.65	+.6	+.9	+12.0	+13.5
Idaho.....	2,700	202,000	74.70	+.6	+1.0	+6.7	+8.7
Ill. 2/.....	33,300	2,737,000	82.15	+.9	-1.6	+10.1	+17.6
Ind.....	3,100	157,000	50.65	+2.9	+3.1	+31.2	+48.1
Iowa.....	2,400	302,000	128.00	+1.3	+2.2	+22.4	+139.5
Kans. 2/.....	5,600	653,000	116.95	-.9	-1.6	+.9	+8.0
Ky. 2/.....	15,300	1,079,000	70.70	+1.0	+.9	+12.8	+13.9
La.....	22,300	1,193,000	53.50	+.2	+.6	+.4	+4.8
Maine 2/.....	2,700	205,000	76.10	+1.1	+2.1	+13.8	+17.1
Md. 2/.....	13,200	1,036,000	78.20	+1.7	+1.6	+27.4	+31.8
Mass.....	14,900	1,414,000	94.95	+.7	+.3	+10.2	+18.9
Mich.....	19,500	1,701,000	87.05	+1.4	+2.2	+20.0	+29.4
Minn.....	8,400	665,000	79.65	+1.0	+.9	+14.4	+25.1
Miss.....	21,800	969,000	44.50	+.4	+.3	+1.7	-2.4
Mo.....	17,200	1,266,000	73.45	+.4	+.6	+4.8	+5.4
Mont.....	1,600	121,000	77.35	+1.2	+1.4	+14.0	+16.1
Nebr. 2/.....	3,400	240,000	70.15	+.4	+1.2	+10.6	+26.4
N. H.....	700	69,300	99.50	+1.0	+.9	+3.0	+12.6
N. J.....	9,900	883,000	89.50	+.2	-.3	+7.8	+10.6
N. Mex. 2/.....	5,900	407,000	69.10	+1.6	+1.5	+24.8	+22.7
N. Y. 2/.....	42,400	4,477,000	105.65	+1.2	+2.4	+12.0	+27.6
N. C.....	23,300	1,649,000	70.65	+.3	+1.7	+1.3	+7.7
N. Dak. 2/.....	1,900	159,000	85.85	+1.1	+2.5	+5.1	+8.0
Ohio.....	24,500	1,767,000	72.15	+2.1	+1.6	+13.8	+14.2
Okla. 2/.....	19,500	1,842,000	94.65	-1.0	-1.2	+2.0	+1.5
Oreg.....	5,200	405,000	78.40	-.7	+.4	-2.6	+1.0
Pa.....	25,900	1,888,000	72.95	-.1	+.1	+2.9	+1.4
P. R. 2/.....	12,500	255,000	20.45	+.1	+115.1	-11.3	+131.4
R. I. 2/.....	3,500	286,000	82.10	+.5	+1.8	+11.5	+19.5
S. C.....	9,200	487,000	52.80	-2.1	-.7	-.5	+9.1
S. Dak.....	1,300	88,100	67.15	-.2	+.8	+.1	+4.0
Tenn.....	18,600	1,215,000	65.45	+1.5	+1.5	+14.9	+15.2
Tex.....	15,600	879,000	56.30	+1.5	+1.4	+37.1	+26.9
Utah.....	3,800	235,000	61.15	-.2	+.6	+12.1	+9.9
Vt. 2/.....	1,500	123,000	82.20	+.9	+.8	+15.5	+20.8
V. I.....	65	2,600	40.75	(5/)	(5/)	(5/)	(5/)
Va.....	7,100	476,000	66.90	+.3	+.7	+2.3	+6.1
Wash.....	10,300	820,000	79.40	+.3	+.9	+11.4	+21.2
W. Va.....	6,200	339,000	54.95	+.7	+1.0	+8.1	+13.6
Wis.....	5,600	350,000	62.20	+.9	+.3	+26.9	+54.1
Wyo.....	840	59,300	71.00	-1.3	-1.9	+2.0	+1.5

1/ All data subject to revision.
2/ Represents aid to the permanently and totally disabled under program for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged.
3/ Decrease of less than 0.05 percent.
4/ Data for May; June data not reported.
5/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients.

Table 6. Aid to families with dependent children: Recipients and payments to recipients, by State, June 1968[1]

[Excludes vendor payments for medical care and cases receiving only such payments]

State	Number of families	Number of recipients		Payments to recipients			Percentage change from--			
					Average per--		May 1968 in--		June 1967 in--	
		Total [2]	Children	Total amount	Family	Recipient	Number of recipients	Amount	Number of recipients	Amount
To Total [3]...	1,383,000	5,609,000	4,207,000	$234,676,000	$169.65	$41.85	-0.1	+2.0	+12.7	+27.1
Ala.	21,400	90,400	72,300	1,368,000	64.05	15.15	+.6	+1.0	+26.8	+51.0
Alaska	1,600	5,800	4,500	220,000	134.95	38.10	+5.3	+13.9	+14.0	+24.8
Ariz.	10,300	43,500	33,000	1,254,000	121.70	28.85	-.5	+.1	+.5	+1.5
Ark.	9,500	39,000	29,500	751,000	79.00	19.25	-.6	-.6	+6.6	+5.3
Calif. [3]	208,000	818,000	594,000	37,255,000	179.05	45.55	-1.3	-1.4	+5.7	+9.6
Colo. [3]	14,300	54,500	41,500	2,164,000	150.90	39.75	-2.0	+2.1	+1.0	+7.4
Conn. [3]	17,000	65,700	49,000	3,414,000	201.20	52.00	-.5	-8.6	+17.0	+26.9
Del. [3]	4,200	17,200	13,000	553,000	131.60	32.25	-2.1	-2.6	+19.4	+20.4
D. C.	5,800	26,500	21,200	1,029,000	178.10	38.90	+.3	+.3	+9.4	+12.6
Fla.	37,900	149,000	119,000	2,263,000	59.75	15.15	+.5	+.6	+5.4	+4.7
Ga.	29,300	115,000	88,500	2,869,000	98.10	24.90	+3.1	+2.8	+20.4	+27.0
Guam [4]	210	1,100	960	40,200	188.95	35.00	---	---	---	---
Hawaii [3]	4,700	19,700	14,500	874,000	184.15	44.40	-2.7	-1.5	+9.0	+11.6
Idaho	3,200	12,200	8,800	569,000	177.25	46.75	-1.4	-1.0	+7.4	+8.5
Ill. [3]	64,900	295,000	230,000	12,971,000	199.80	43.95	+.1	-1.4	+15.1	+21.9
Ind.	12,800	53,200	40,300	1,735,000	135.90	32.65	-.7	+.4	+7.9	+23.8
Iowa	13,500	52,100	38,100	2,567,000	190.65	49.25	+1.0	+1.4	+15.6	+32.0
Kans. [3]	9,900	41,000	31,900	1,805,000	181.50	44.00	-1.1	-.4	+13.0	+15.1
Ky.	27,900	109,000	79,100	3,108,000	111.25	28.50	+.3	+.4	+12.7	+15.0
La.	32,000	141,000	109,000	3,330,000	103.90	23.65	(5/)	-.1	+21.7	+21.1
Maine	6,000	22,300	16,300	663,000	110.25	29.70	-.4	+.1	+6.8	+6.6
Md. [3]	27,900	111,000	85,800	4,332,000	155.15	39.00	+.2	+.1	+11.3	+15.2
Mass. [3]	40,300	149,000	111,000	8,319,000	206.20	55.85	+1.5	+1.4	+22.0	+29.2
Mich. [3]	48,200	197,000	148,000	8,883,000	184.40	45.15	-.4	-.2	+17.1	+25.5
Minn.	16,900	61,600	47,600	3,328,000	196.35	54.00	+.6	+1.0	+9.4	+21.6
Miss.	25,200	103,000	84,400	870,000	34.55	8.50	+.7	+.9	+10.0	-.3
Mo.	28,100	116,000	89,500	2,864,000	102.10	24.65	+.5	+.4	+6.3	+5.2
Mont.	2,700	9,900	7,600	367,000	138.30	36.95	-1.0	-.1	+6.3	+5.5
Nebr. [3]	6,100	24,500	18,800	902,000	147.85	36.85	-.3	-.4	+17.0	+47.3
Nev.	2,300	8,600	6,500	264,000	116.95	30.90	+.4	+.5	+23.0	+20.3
N. H.	1,500	6,200	4,700	269,000	177.65	43.35	-.1	+1.0	+11.4	+22.4
N. J.	39,900	159,000	120,000	9,242,000	231.40	58.25	+1.0	+1.7	+19.5	+23.8
N. Mex.	10,200	41,400	31,300	1,276,000	125.10	30.85	+1.1	+1.5	+15.2	+16.0
N. Y. [3]	217,000	853,000	625,000	61,210,000	282.35	71.75	+.9	+5.7	+21.4	+58.1
N. C.	26,300	107,000	81,200	2,772,000	105.45	25.85	-1.0	-.7	-1.4	+3.0
N. Dak.	2,500	9,900	7,500	472,000	188.55	47.90	-2.2	-.5	+8.3	+14.4
Ohio [3]	56,500	231,000	172,000	8,647,000	152.95	37.50	-.2	-.1	+15.9	+30.0
Okla. [3]	22,900	88,700	66,700	3,053,000	133.20	34.40	-1.4	-1.3	+2.0	+1.8
Oreg. [3]	10,500	39,600	28,200	1,592,000	152.25	40.25	-6.0	-6.1	+1.9	+4.8
Pa. [3]	72,300	306,000	225,000	11,789,000	163.00	38.55	-.7	+.2	+15.0	+21.8
P. R.	35,300	174,000	130,000	2,796,000	79.20	16.10	+.2	+202.5	-1.4	+263.5
R. I. [3]	8,000	31,000	22,800	1,482,000	185.45	47.80	+.1	+8.1	+12.8	+29.6
S. C.	7,900	30,900	24,900	569,000	72.20	18.45	+.2	+.3	+24.7	+33.8
S. Dak.	3,700	13,800	10,400	615,000	165.35	44.45	-.7	+6.6	+5.0	+11.7
Tenn.	25,400	100,000	77,200	2,655,000	104.70	26.45	+.6	+1.9	+10.8	+9.8
Tex.	30,200	141,000	108,000	2,875,000	95.10	20.45	+.7	+.5	+32.8	+27.7
Utah [3]	6,900	27,000	19,300	1,031,000	150.10	38.25	-2.1	-.6	+14.3	+17.3
Vt.	2,500	9,200	6,700	431,000	174.45	46.75	+2.0	+3.2	+30.0	+105.6
V. I.	410	1,600	1,400	46,700	114.95	28.75	+1.1	-.5	+12.6	+15.1
Va.	14,600	60,600	46,700	1,874,000	128.00	30.90	-.8	+.1	+12.0	+19.7
Wash. [3]	17,900	65,400	47,000	3,118,000	174.10	47.65	-3.5	-2.7	+10.7	+19.3
W. Va. [3]	19,600	88,100	61,900	2,255,000	115.00	25.60	-2.4	-3.0	+9.4	-7.6
Wis. [3]	17,800	69,600	52,500	3,500,000	196.10	50.30	+.6	+1.5	+28.4	+48.2
Wyo.	1,200	4,600	3,500	174,000	141.90	38.05	-3.4	-3.7	+5.3	+7.9

1/ All data subject to revision.
2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance.
3/ Includes data on unemployed-parent segment; see table 7.
4/ Data for May; June data not reported.
5/ Increase of less than 0.05 percent.

Table 7. Aid to families with dependent children, unemployed-parent segment: Recipients and payments to recipients, by State, June 1968[1]

[Excludes vendor payments for medical care and cases receiving only such payments]

State	Number of families	Number of recipients		Payments to recipients			Percentage change from--			
					Average per--		May 1968 in--		June 1967 in--	
		Total 2/	Children	Total	Family	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total...	62,600	348,000	234,000	$14,402,000	$230.10	$41.45	-9.5	-7.7	-5.7	+7.7
Calif.....	22,500	128,000	84,200	4,744,000	211.05	37.15	-10.5	-11.6	-11.3	-10.1
Colo.....	860	5,100	3,300	208,000	241.80	41.15	-14.8	-11.9	-33.1	-27.4
Conn.....	320	1,800	1,200	87,600	277.10	49.90	-30.3	-36.2	-46.8	-12.0
Del.....	170	980	680	30,800	186.70	31.35	-23.0	-22.0	-24.7	-21.5
Hawaii.....	370	2,200	1,500	92,100	247.65	41.75	-13.6	-11.7	+8.2	+19.2
Ill.....	3,300	21,000	14,500	861,000	259.65	40.95	-8.0	-8.9	+9.3	+16.8
Kans.....	280	1,700	1,200	65,000	233.10	37.90	-6.2	-5.2	+42.9	+58.3
Md.....	200	1,100	730	39,500	198.55	35.40	-17.7	-14.3	-37.2	-33.7
Mass.....	690	3,800	2,600	201,000	290.20	52.55	-.2	-1.2	+14.0	+19.4
Mich.....	1,800	11,400	7,800	457,000	253.00	40.05	-12.6	-10.0	-.2	+5.0
Nebr.....	94	590	430	20,200	214.65	33.95	-.3	+1.3	+60.5	+153.5
N. Y.....	16,000	79,000	54,800	4,723,000	295.85	59.80	-4.9	-.4	+6.0	+41.7
Ohio.....	2,900	17,400	11,800	619,000	214.80	35.50	-11.1	-11.0	+.7	+15.3
Okla.....	560	3,400	2,300	111,000	197.80	33.05	-12.6	-12.1	+.7	+2.1
Oreg.....	1,100	5,800	3,800	224,000	202.25	38.90	-24.5	-24.0	-25.3	-16.0
Pa.....	3,000	16,800	11,100	497,000	166.35	29.55	-10.0	-5.8	+9.8	+24.7
R. I.....	380	2,200	1,500	86,700	226.35	39.55	-10.4	-.2	+30.3	+54.0
Utah.....	1,100	6,000	4,100	177,000	162.40	29.40	-6.2	-4.3	+19.7	+54.8
Wash.....	490	2,400	1,500	97,700	201.55	41.00	-35.2	-34.0	-53.6	-49.2
W. Va.....	5,700	32,500	21,600	850,000	149.15	26.15	-6.6	-6.8	-19.4	-17.0
Wis.....	850	4,800	3,200	210,000	247.05	43.45	-8.4	-10.2	+87.0	+96.9

1/ Data for this segment of the program, shown separately here, are included in data for the total program. All data subject to revision.

2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance.

Table 8. General assistance: Recipients and payments to recipients for selected cities, June 1968

[Excludes vendor payments for medical care and cases receiving only such payments]

City	Number of--		Payments to recipients			Percentage change from--			
				Average per--		May 1968 in--		June 1967 in--	
	Cases	Recipients	Total amount	Case	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total, 17 cities 1/..	166,000	306,000	$18,670,000	$112.20	$60.95	-2.9	+2.2	+21.4	+45.3
Baltimore.....	5,500	6,600	473,000	85.85	71.55	-1.5	-1.8	-11.9	-14.0
Boston.....	4,100	6,400	453,000	111.70	70.60	-3.6	+2.8	+56.6	+41.1
Buffalo 2/.....	4,200	6,100	413,000	98.65	68.15	+.3	-9.4	+8.3	+18.2
Chicago.....	15,900	32,100	1,794,000	113.15	55.80	-3.9	-1.2	+9.1	+27.9
Cincinnati 2/.....	5,000	16,600	383,000	75.80	23.10	-1.3	-1.5	-.8	+2.8
Cleveland 2/.....	6,800	17,600	581,000	85.05	33.05	-2.6	-5.5	-12.5	-8.7
Detroit.....	(1/)	(1/)	(1/)	---	---	---	---	---	---
District of Columbia....	920	1,000	73,900	80.10	73.00	-17.1	-13.7	-.4	-10.7
Los Angeles 2/.....	15,600	25,200	1,023,000	65.70	40.60	-26.5	-13.1	+20.2	-8.6
Milwaukee 2/.....	2,400	5,000	227,000	95.40	45.00	-10.8	-7.2	-10.1	+7.1
Minneapolis.....	1,600	3,500	143,000	87.20	40.45	-3.7	-4.5	+20.3	+26.5
New Orleans.....	1,000	1,100	56,000	54.55	49.90	-.3	+.1	+29.2	+28.4
New York.....	75,300	148,000	10,901,000	144.70	73.75	+1.6	+6.8	+38.4	+83.0
Philadelphia.....	11,000	15,700	898,000	82.00	57.20	+.8	+1.0	+36.1	+38.6
Pittsburgh.....	8,300	9,400	646,000	77.55	68.55	-1.1	-.5	+9.1	+8.2
Rochester.....	800	2,200	86,600	107.75	39.90	-6.1	-.2	+17.7	+46.6
St. Louis.....	2,000	2,200	126,000	64.30	58.30	+.2	+.9	-7.2	+5.2
San Francisco.....	6,000	7,900	394,000	65.25	49.75	+14.6	-3.5	(3/)	(3/)

1/ Data not reported for Detroit. Percentage changes based on comparable data.
2/ Data for county in which city is located.
3/ Data not reported for San Francisco for June 1967.

Table 9. General assistance: Recipients and payments to recipients, by State, June 1968[1]

/Excludes vendor payments for medical care and cases receiving only such payments/

State	Number of--		Payments to recipients			Percentage change from--			
				Average per--		May 1968 in--		June 1967 in--	
	Cases	Recipients	Total amount	Case	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total 2/	356,000	737,000	$32,927,000	$92.60	$44.65	-1.6	-1.1	+10.7	+27.5
Ala.	77	77	1,100	14.40	14.40	(3/)	(3/)	(3/)	(3/)
Alaska	130	440	9,200	69.20	21.15	-37.8	-28.3	-26.0	-9.2
Ariz.	2,000	5,600	105,000	52.70	18.60	-7.7	-2.3	+10.0	+1.0
Ark.	190	670	2,600	13.85	3.95	-26.5	-25.9	-35.5	-36.6
Calif.	30,800	47,900	2,190,000	71.15	45.70	-15.2	-8.7	+14.2	+.8
Colo.	1,000	3,200	39,400	39.25	12.45	-7.1	-14.3	-14.6	-1.4
Conn. 4/	5,900	15,900	495,000	83.95	31.10	-4.6	-2.1	+16.8	+27.7
Del.	1,900	4,100	114,000	60.00	28.20	-2.2	-2.7	+40.7	+34.8
D. C.	920	1,000	73,900	80.10	73.00	-17.1	-13.7	-.4	-10.7
Fla. 4/	8,100	(5/)	244,000	---	---	---	---	---	---
Ga.	2,400	5,500	84,500	34.65	15.40	+2.1	-.2	+7.7	+7.1
Guam 6/	46	60	2,800	(3/)	46.40	---	---	---	---
Hawaii	1,400	2,400	139,000	96.20	57.30	-2.4	+1.3	+12.2	+18.1
Ill.	24,100	52,100	2,295,000	95.20	44.10	-3.1	-2.1	+4.6	+19.8
Iowa 4/	2,900	6,600	121,000	---	---	---	---	---	---
Kans.	2,800	5,700	240,000	85.30	41.70	-4.1	-2.8	+9.8	+19.7
La.	6,500	7,000	331,000	51.30	47.05	-.5	-.5	+7.7	+10.4
Maine	2,100	7,100	88,800	42.45	12.45	-7.0	-11.9	+19.3	-.4
Md.	6,500	7,700	551,000	84.90	71.25	-1.5	-1.5	-10.7	-11.4
Mass.	9,800	20,800	922,000	94.40	44.40	-2.9	-4.0	+24.6	+26.9
Mich.	22,700	69,200	2,155,000	95.10	31.15	+17.6	-10.7	+32.2	+25.3
Minn.	6,100	17,400	537,000	88.50	30.75	-6.8	-9.2	+5.1	+18.1
Miss.	1,300	1,500	25,100	19.15	16.35	-5.2	+1.6	-3.3	+10.7
Mo.	10,100	12,500	656,000	64.75	52.40	-1.8	-1.8	+2.3	+1.2
Mont.	910	3,000	53,300	58.45	17.55	-17.6	-22.3	+6.7	-.3
N. H.	680	2,100	42,600	62.90	20.25	-11.3	-7.9	-8.6	-13.7
N. J. 7/	11,900	35,100	1,510,000	126.65	43.00	-3.1	-2.2	+4.2	+6.3
N. Mex.	240	630	8,500	35.55	13.60	+9.8	-3.8	-8.2	-54.4
N. Y.	96,200	197,000	13,254,000	137.80	67.15	+.6	+4.7	+32.5	+70.2
N. C.	1,600	3,900	47,000	29.30	12.05	-7.8	+3.5	-8.8	+12.0
N. Dak.	230	880	12,000	52.85	13.55	-18.1	-24.3	-19.6	-11.4
Ohio	23,000	60,600	2,140,000	93.05	35.35	-1.6	-1.9	-14.9	-8.2
Okla.	1,000	(5/)	18,400	18.35	---	---	-6.5	---	-80.0
Oreg.	2,100	(5/)	111,000	53.75	---	---	-8.1	---	-49.8
Pa.	33,800	43,500	2,543,000	75.30	58.40	-.1	+.5	+22.4	+21.4
R. I.	4,100	11,700	302,000	73.65	25.85	+1.9	-11.0	+16.0	+9.3
S. C.	760	900	29,500	38.85	32.90	-4.0	-4.1	-.7	+2.7
S. Dak.	230	740	8,500	36.40	11.45	-17.9	-17.0	-23.2	-16.2
Tenn.	1,300	3,300	44,200	34.00	13.50	-11.7	-6.2	+35.0	-.8
Tex. 4/	9,800	(5/)	228,000	---	---	---	---	---	---
Utah	1,300	1,500	102,000	79.75	68.40	-4.7	-5.5	+89.3	+89.7
Vt. 4/	400	(5/)	13,000	---	---	---	---	---	---
V. I.	160	170	6,500	41.95	38.25	-3.4	-2.0	+.6	+2.7
Va.	3,800	7,800	213,000	56.05	27.15	-8.2	-6.4	-.7	+20.2
Wash.	7,500	12,600	667,000	89.35	52.85	-6.8	-7.4	+20.3	+20.9
W. Va.	1,600	2,600	77,800	48.35	30.40	-1.3	-.2	-9.4	-1.9
Wis.	4,200	10,500	333,000	78.60	31.65	-8.1	-12.5	-6.0	+2.3
Wyo.	180	520	12,800	71.65	24.30	-17.1	-13.1	-37.1	-19.7

1/ All data subject to revision.
2/ Partly estimated; does not represent sum of State figures because totals exclude for New Jersey an estimated number of cases and persons receiving only medical care, hospitalization, and/or burial and payments for such services; recipient count includes an estimate for States not reporting such data. Excludes Idaho, Indiana, Kentucky, Nebraska, Nevada, and Puerto Rico; data not available.
3/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients.
4/ Estimated.
5/ Data not available.
6/ Data for May; June data not reported.
7/ Includes an unknown number of cases and persons receiving only medical care, hospitalization, and/or burial and payments for such services.

Table 10. Amount of vendor payments for medical care for recipients of public assistance, by program and State, June 1968[1]

State	Total	Percentage change from--		Medical assistance	Medical assistance for the aged	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled	Aid to families with dependent children	General assistance [2]
		May 1968	June 1967							
Total	[3] $349,391,000	+3.8	+52.5	[3] $324,343,000	$5,480,000	$9,054,000	$257,000	$3,150,000	$2,340,000	$4,767,000
Ala.	1,551,000	+.1	+23.6	---	740	1,408,000	5,800	139,000	---	---
Alaska [4]	193,000	+19.9	+315.1	---	---	38,600	900	31,100	---	122,000
Ariz.	153,000	-6.1	+2.0	---	1,000	152,000	---	---	---	---
Ark. [4]	1,791,000	-.7	+17.2	---	339,000	969,000	35,300	362,000	86,100	---
Calif.	62,903,000	+22.1	+59.1	62,903,000	---	---	---	---	---	---
Colo.	2,282,000	-2.5	+8.8	---	[5] 1,310,000	486,000	6,100	194,000	242,000	44,200
Conn.	6,345,000	+44.8	+80.5	6,345,000	---	---	---	---	---	---
Del.	239,000	-3.6	-14.0	239,000	---	---	---	---	---	---
D. C.	118,000	-74.8	(6)	---	106,000	2,100	64	690	3,500	5,700
Fla.	2,202,000	+10.0	+13.6	---	---	1,713,000	20,000	304,000	165,000	---
Ga.	5,407,000	+54.8	+185.2	5,407,000	---	---	---	---	---	---
Guam [7]	1,900	---	---	1,900	---	---	---	---	---	---
Hawaii	678,000	-25.2	-29.8	654,000	---	---	---	---	---	23,600
Idaho	550,000	+1.9	+13.4	550,000	---	---	---	---	---	---
Ill.	14,152,000	-.4	+88.9	13,218,000	---	---	---	---	---	934,000
Ind.	2,798,000	-2.2	+25.8	---	412,000	1,306,000	86,700	470,000	523,000	---
Iowa	2,170,000	-29.7	+14.1	2,062,000	---	---	---	---	---	[8] 108,000
Kans.	3,829,000	+35.1	+136.2	3,829,000	---	---	---	---	---	---
Ky.	4,178,000	-22.7	+24.0	4,178,000	---	---	---	---	---	---
La.	4,401,000	+2.2	+33.4	4,310,000	---	---	---	---	---	91,300
Maine	1,246,000	+16.2	+22.4	1,155,000	---	---	---	---	---	91,100
Md.	9,188,000	+18.0	+67.3	9,188,000	---	---	---	---	---	---
Mass.	21,940,000	+14.5	+27.4	21,556,000	---	---	---	---	---	384,000
Mich.	17,510,000	+39.0	+77.7	17,359,000	---	---	---	---	---	151,000
Minn.	7,787,000	+4.9	+23.5	7,485,000	---	---	---	---	---	302,000
Miss.	331,000	+4.1	+63.9	---	---	287,000	2,200	41,300	---	---
Mo.	4,335,000	+7.3	+286.4	4,335,000	---	---	---	---	---	---
Mont.	852,000	-3.1	+33.1	565,000	---	---	---	---	---	287,000
Nebr.	1,769,000	-18.7	-4.1	1,769,000	---	---	---	---	---	---
Nev.	601,000	-24.5	+268.7	601,000	---	---	---	---	---	---
N. H. [7]	330,000	---	---	330,000	---	---	---	---	---	---
N. J.	4,455,000	+.5	+64.8	---	[5] 2,976,000	210,000	16,000	380,000	600,000	273,000
N. Mex.	1,579,000	+18.8	+63.5	1,553,000	---	---	---	---	---	26,400
N. Y.	88,237,000	-2.1	+65.1	88,237,000	---	---	---	---	---	---
N. C.	1,802,000	+9.1	+15.5	---	123,000	224,000	28,600	802,000	498,000	126,000
N. Dak.	843,000	-10.2	+1.8	832,000	---	---	---	---	---	10,500
Ohio	7,935,000	-10.9	+51.5	6,680,000	---	---	---	---	---	1,255,000
Okla.	6,545,000	+14.6	+41.2	6,545,000	---	---	---	---	---	---
Oreg.	1,578,000	-25.7	+29.6	1,490,000	---	---	---	---	---	88,200
Pa.	14,086,000	-7.4	+24.9	14,086,000	---	---	---	---	---	---
P. R. [7]	3,439,000	---	---	3,439,000	---	---	---	---	---	---
R. I.	2,565,000	+9.7	+44.3	2,480,000	---	---	---	---	---	85,000
S. C.	833,000	-7.6	-37.2	---	---	596,000	35,400	153,000	36,500	12,300
S. Dak.	748,000	0	+28.5	678,000	---	---	---	---	---	70,500
Tenn.	1,440,000	+9.8	+13.9	---	125,000	1,153,000	3,900	78,000	80,200	---
Tex.	11,795,000	+7.1	+172.0	11,795,000	---	---	---	---	---	---
Utah	861,000	-4.7	+7.5	861,000	---	---	---	---	---	240
Vt.	995,000	+22.5	+26.6	995,000	---	---	---	---	---	---
V. I.	(3)	---	---	(3)	---	---	---	---	---	---
Va.	963,000	+5.6	+29.6	---	87,500	512,000	16,000	195,000	106,000	46,400
Wash.	4,335,000	-18.7	+4.7	4,335,000	---	---	---	---	---	---
W. Va.	1,138,000	+20.3	+35.5	1,073,000	---	---	---	---	---	65,300
Wis.	11,215,000	-39.3	+42.9	11,116,000	---	---	---	---	---	99,100
Wyo.	173,000	+16.9	+6.1	108,000	---	---	---	---	---	65,300

1/ Amounts represent primarily bills paid during the month and therefore are subject to fluctuations unrelated to provisions of medical services. All data subject to revision.
2/ Data incomplete for general assistance. Some States do not report these data and for some the data represent only partial reporting.
3/ Data not reported by Virgin Islands.
4/ Except for aid to families with dependent children and general assistance, data represent payments for recipients of the specified types of assistance under program for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged.
5/ Excludes small amount of money payments not subject to Federal participation.
6/ Increase of more than 1,000 percent.
7/ Data for May; June data not reported.
8/ Partly estimated.

Table 11. Amount of medical vendor payments for public assistance programs under the Social Security Act, by form of payment and State, June 1968[1]

State	Total	Form of medical vendor payments	
		Payments to vendors directly or through fiscal agent	Premium or per capita payments 2/
Total 3/	$344,623,000	$328,103,000	$16,521,000
Title XIX States 3/	324,343,000	311,531,000	12,814,000
Other States	20,280,000	16,572,000	3,707,000
Title XIX States			
Calif.	62,903,000	61,701,000	1,202,000
Conn.	6,345,000	6,316,000	28,400
Del.	239,000	231,000	7,900
Ga.	5,407,000	4,660,000	748,000
Guam	1,900	560	1,400
Hawaii	654,000	654,000	---
Idaho	550,000	528,000	21,900
Ill.	13,218,000	13,218,000	---
Iowa	2,062,000	1,967,000	94,700
Kans.	3,829,000	3,735,000	93,800
Ky.	4,178,000	3,924,000	254,000
La.	4,310,000	4,310,000	---
Maine	1,155,000	1,108,000	47,100
Md.	9,188,000	9,188,000	---
Mass.	21,556,000	21,554,000	1,900
Mich.	17,359,000	17,359,000	---
Minn.	7,485,000	7,383,000	101,000
Mo.	4,335,000	3,981,000	354,000
Mont.	565,000	550,000	15,400
Nebr.	1,769,000	1,721,000	47,100
Nev.	601,000	601,000	---
N. H. 4/	330,000	313,000	17,200
N. Mex.	1,553,000	1,553,000	---
N. Y.	88,237,000	88,019,000	219,000
N. Dak.	832,000	784,000	2/ 48,400
Ohio	6,680,000	6,680,000	---
Okla.	6,545,000	1,925,000	2/ 4,620,000
Oreg.	1,490,000	1,490,000	---
Pa.	14,086,000	14,086,000	---
P. R. 4/	3,439,000	3,439,000	---
R. I.	2,480,000	2,480,000	---
S. Dak.	678,000	658,000	20,100
Tex.	11,795,000	7,106,000	2/ 4,689,000
Utah	861,000	861,000	---
Vt.	995,000	978,000	17,300
Wash.	4,335,000	4,201,000	2/ 135,000
W. Va.	1,073,000	1,073,000	---
Wis.	11,116,000	11,087,000	29,000
Wyo.	108,000	108,000	---
Other States			
Ala.	1,551,000	1,551,000	---
Alaska	70,500	70,500	---
Ariz.	153,000	110,000	43,000
Ark.	1,791,000	1,540,000	251,000
Colo.	2,239,000	1,864,000	2/ 375,000
D. C.	112,000	112,000	---
Fla.	2,202,000	1,905,000	296,000
Ind.	2,797,000	2,518,000	2/ 279,000
Miss.	331,000	331,000	---
N. J.	4,182,000	4,122,000	59,600
N. C.	1,675,000	777,000	2/ 898,000
S. C.	821,000	729,000	91,500
Tenn.	1,440,000	127,000	2/ 1,313,000
Va.	916,000	815,000	2/ 101,000

1/ All data subject to revision.
2/ Entries represent premium payments into the Social Security Administration system for Supplementary Medical Insurance except for premium payments into an agency pooled fund by North Carolina-$898,000; Oklahoma-$4,306,000; Tennessee-$1,313,000; and premium payments to health-insuring agencies by Colorado-$236,000; Indiana-$201,000; North Dakota-$31,100; Texas-$3,773,000; Virginia-$57,700; and Washington-$510.
3/ Data not reported for Virgin Islands.
4/ Data for May; June data not reported.

Table 12. Old-age, survivors, disability, and health insurance, summary benefit data, June 1968

CASH BENEFITS AWARDED AND IN CURRENT-PAYMENT STATUS

Type of beneficiary	Benefit awards		Benefits in current-payment status			Amount of benefits paid 1/ (in thousands)
	Number	Average amount	Number	Average amount	Monthly rate (in thousands)	
Total monthly beneficiaries	315,572	---	24,120,797	---	$2,013,401	$2,084,996
Retired workers and dependents	155,494	---	15,345,493	---	1,352,853	1,376,116
Retired workers	110,972	$102.66	12,188,476	$98.33	1,198,448	1,211,754
Wives and husbands 2/	28,855	48.49	2,635,481	51.03	134,496	143,366
Children 3/	15,667	40.38	521,536	38.17	19,909	20,996
Disabled workers and dependents	62,005	---	2,257,793	---	175,280	193,838
Disabled workers	27,843	115.21	1,245,154	111.63	138,991	152,096
Wives and husbands 2/	8,045	38.46	244,476	38.34	9,373	11,130
Children 3/	26,117	34.63	768,163	35.05	26,916	30,612
Survivors of deceased workers	91,664	---	5,815,987	---	457,737	486,859
Widowed mothers	9,956	75.14	493,789	74.47	36,772	39,323
Children 3/	49,578	67.06	2,446,681	70.90	173,469	182,253
Widows and widowers 4/	31,933	88.96	2,843,153	86.05	244,652	262,122
Parents	197	97.80	32,364	87.91	2,845	3,161
Persons with special age-72 benefits 5/	6,409	---	701,524	---	27,531	28,183
Primary	6,153	---	680,351	39.84	27,108	27,744
Wives	256	---	21,173	19.97	423	439
Lump-sum death payments 6/	101,815	240.26	---	---	---	22,783

1/ Exceeds monthly rate of benefits in current-payment status because of the inclusion in initial payments of amounts payable for prior months. Distribution by type of monthly benefit estimated.

2/ Includes wives under age 65 with entitled children in their care; a total of 374,000 such wives of retired and disabled workers were in current-payment status.

3/ Includes disabled persons aged 18 and over whose disability began before age 18.

4/ Includes widows and divorced wives aged 60-61 entitled under the 1965 amendments and disabled widows and widowers aged 50-61 entitled under the 1967 amendments.

5/ Represents benefits authorized by Public Law 89-368(1966) for certain persons aged 72 and over who are not insured under the regular or transitional insured-status provisions of the Social Security Act.

6/ Number of lump-sum payments shown were paid on the accounts of 94,823 deceased workers; the average amount represents average per deceased worker.

Program and Operating Statistics

Public Assistance in June and July 1968

July

More than 9.1 million persons received money payments under public assistance programs in July--an increase of 64,000 from the June total. This rise, like that in July 1967, was in contrast to the decrease that has typically occurred in this month over the years. The factor contributing most to the increase in July 1968 was a rise of 43,000, or 0.8 percent, in aid to families with dependent children, exclusive of the unemployed-parent segment. A large part (19,000) of the national increase was accounted for by New York, where the number of recipients has risen substantially during the past year. In addition, relatively sizable July increases of 2,000 to 3,000 recipients were reported by Alabama, Florida, Georgia, and Louisiana. Nationally, the number of general assistance recipients rose by 35,400, or 4.8 percent, reflecting increases in three of every five States. An increase of 4,300, or 0.6 percent, occurred in aid to the permanently and totally disabled. The numbers of persons aided under old-age assistance and aid to the blind changed very little.

Total expenditures for assistance in July were $801.7 million, including $328.3 million, or 41.0 percent, in vendor payments for medical care. Among the programs, the largest change in payments was the decrease of $20.6 million in bills paid for medical assistance. More than $13.2 million of that decrease was accounted for by California's program under title XIX. Money payments rose by $7.4 million; all programs showed increases. As in other recent months, California and New York continued to play a substantial role in national changes in aggregate money payments. Increases in such payments in July for all programs combined were $1.9 million in California and $2.2 million in New York. In Florida money payments for aid to families with dependent children alone rose by $930,000 when the State removed its maximums on individual monthly payments and began to meet 65 percent of budget deficits.

In July a number of States made changes that had or will have a noticeable effect on their programs. For aid to families with dependent children, Alabama discontinued its provision that made stepfathers liable for support of unadopted children. Tennessee broadened the coverage of its program for aid to families with dependent children by rescinding its policy relating to "substitute spouses." Alaska raised maximum payments in aid to families with dependent children by $25 for an adult and child and by $10 for each additional child. Missouri raised maximum payments in old-age assistance (from $75 to $80) and in aid to families with dependent children (from $33 to $43 for the first child only). Both Florida and North Carolina provided higher food allowances in all programs in July and increased payment rates for certain types of institutional care. South Carolina began operating a program of medical assistance under title XIX, bringing to 41 the number of States with such programs. Vermont extended aid to families with dependent children to cover families in need because of unemployment of the father and thus brought to 22 the number of States aiding such families.

Table 1. Amount of public assistance payments in the United States, by month, July 1967-July 1968[1]

Year and month	Total	Money payments 2/							Medical vendor payments 3/					
		Total	Federally aided programs					General assistance 5/	Total	Federally aided programs				General assistance 5/
			Total	Old-age assistance 4/	Aid to the blind 4/	Aid to the permanently and totally disabled 4/	Aid to families with dependent children			Total	Medical assistance 6/	Medical assistance for the aged 4/	Other	
	Amount of assistance (In thousands)													
1967														
July	$629,482	$408,221	$382,390	$141,668	$7,295	$47,951	$185,476	$25,831	$221,261	$216,933	$190,184	$6,472	$20,277	$4,328
August	678,341	416,861	389,058	142,132	7,348	49,057	190,521	27,803	261,480	256,332	231,053	5,023	20,256	5,148
September	672,973	423,302	394,979	141,645	7,365	49,610	196,359	28,323	249,671	244,926	223,515	5,173	16,238	4,745
October	705,942	432,664	403,477	143,640	7,400	50,576	201,861	29,187	273,278	269,134	249,788	5,013	14,333	4,143
November	717,664	436,611	407,068	144,588	7,406	51,125	203,949	29,543	281,053	276,471	258,164	5,151	13,156	4,579
December	713,589	445,526	414,690	145,425	7,475	52,054	209,736	30,836	268,063	263,375	244,875	4,920	13,580	4,688
1968														
January	760,705	454,739	422,104	145,603	7,505	52,689	216,307	32,635	305,966	301,891	282,708	5,508	13,675	4,075
February	742,761	455,226	423,011	144,748	7,436	52,828	217,999	32,215	287,535	282,535	263,231	5,460	13,844	5,001
March	774,466	455,621	422,857	140,385	7,374	52,696	222,402	32,764	318,845	314,704	295,153	5,388	14,163	4,139
April	844,112	457,290	424,484	136,733	7,345	53,313	227,093	32,806	386,822	381,691	362,049	5,332	14,310	5,131
May	797,684	461,177	427,896	136,661	7,375	53,802	230,058	33,281	336,507	331,456	311,170	5,675	14,611	5,051
June	815,439	466,048	433,121	136,756	7,388	54,301	234,676	32,927	349,391	344,624	324,343	5,480	14,801	4,767
July	801,741	473,407	438,198	138,160	7,411	55,125	237,502	35,209	328,334	323,513	303,789	5,961	13,763	4,821
	Percentage change from preceding month													
1967														
July	-0.8	+0.7	+0.7	+0.8	+0.5	+1.5	+0.5	-0.1	-3.4	-3.2	-3.0	+39.2	-13.1	-14.7
August	+7.8	+2.1	+1.7	+.3	+.7	+2.3	+2.7	+7.6	+18.2	+18.2	+21.5	-22.4	-.1	+18.9
September	-.8	+1.5	+1.5	-.3	+.2	+1.1	+3.1	+1.9	-4.5	-4.4	-3.3	+3.0	-19.8	-7.8
October	+4.9	+2.2	+2.2	+1.4	+.5	+1.9	+2.8	+3.0	+9.5	+9.9	+11.8	-3.1	-11.7	-12.7
November	+1.7	+.9	+.9	+.7	+.1	+1.1	+1.0	+1.2	+2.8	+2.7	+3.4	+2.8	-8.2	+1.05
December	-.6	+2.0	+1.9	+.6	+.9	+1.8	+2.8	+4.4	-4.6	-4.7	-5.1	-4.5	+3.2	+2.4
1968														
January	+6.6	+2.1	+1.8	+.1	+.4	+1.2	+3.1	+5.8	+14.1	+14.6	+15.4	+12.0	+.7	-13.1
February	-2.4	+.1	+.2	-.6	-.9	+.3	+.8	-1.3	-6.0	-6.4	-6.9	-.9	+1.2	+22.7
March	+4.3	+.1	(7/)	-3.0	-.8	-.3	+2.0	+1.7	+10.9	+11.4	+12.1	-1.3	+2.3	-17.2
April	+9.0	+.4	+.4	-2.6	-.4	+1.2	+2.1	+.1	+21.3	+21.3	+22.7	-1.0	+1.0	+24.0
May	-5.5	+.8	+.8	-.1	+.4	+.9	+1.3	+1.4	-13.0	-13.2	-14.1	+6.4	+2.1	-1.6
June	+2.2	+1.1	+1.2	+.1	+.2	+.9	+2.0	-1.1	+3.8	+4.0	+4.2	-3.4	+1.3	-5.6
July	-1.7	+1.6	+1.2	+1.0	+.3	+1.5	+1.2	+6.9	-6.0	-6.1	-6.3	+8.8	-7.0	+1.1
	Percentage change from same month of preceding year													
1968														
July	+27.4	+16.0	+14.6	-2.5	+1.6	+15.0	+28.1	+36.4	+48.4	+49.1	+59.7	-7.9	-32.1	+11.4

1/ All data subject to revision.
2/ Includes nonmedical vendor payments.
3/ Amounts represent primarily bills paid during the month and therefore are subject to fluctuations unrelated to provisions of medical services.
4/ Represents data for recipients of the specified types of assistance under separate State programs and under State programs for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged.
5/ Partly estimated. Does not include Idaho, Indiana, Kentucky, Nebraska, and Puerto Rico for all months, and Nevada beginning January 1968; data not available. Percentage changes based on comparable data.
6/ Data incomplete.
7/ Decrease of less than 0.05 percent.

Table 2. Number of recipients of public assistance money payments in the United States, by month, July 1967-July 1968[1]

Table 2. Number of recipients of public assistance money payments in the United States, by month, July 1967-July 1968[1]

Year and month	Federally aided programs								General assistance 2/	
	Total	Adult programs				Aid to families with dependent children				
		Total	Old-age assistance 3/	Aid to the blind 3/	Aid to the permanently and totally disabled 3/	Families	Total recipients 4/	Children	Cases	Recipients
	Number of recipients (In thousands)									
1967										
July	7,742	2,764	2,062	82.8	618	1,212	4,978	3,745	313	678
August	7,834	2,776	2,068	82.9	625	1,232	5,058	3,802	332	726
September	7,879	2,777	2,065	82.8	629	1,244	5,102	3,838	333	729
October	7,937	2,788	2,070	82.8	636	1,258	5,148	3,871	335	735
November	8,004	2,797	2,074	82.8	640	1,273	5,207	3,907	342	758
December	8,111	2,802	2,073	82.7	646	1,297	5,309	3,986	352	782
1968										
January	8,238	2,804	2,070	82.5	651	1,327	5,442	4,080	365	817
February	8,316	2,796	2,060	82.3	654	1,346	5,520	4,132	363	798
March	8,369	2,782	2,044	81.7	656	1,365	5,587	4,180	365	792
April	8,381	2,769	2,028	81.4	660	1,374	5,612	4,203	360	762
May	8,385	2,770	2,023	81.2	666	1,380	5,615	4,209	358	749
June	8,379	2,770	2,019	81.2	670	1,383	5,609	4,207	356	737
July	8,408	2,775	2,020	81.0	674	1,397	5,633	4,226	369	773
	Percentage change from preceding month									
1967										
July	(5/)	(5/)	-0.1	-0.2	+0.6	+0.3	(5/)	+0.1	+0.7	+2.2
August	+1.2	+.4	+.3	+.1	+1.1	+1.7	+1.6	+1.5	+6.2	+7.0
September	+.6	(5/)	-.1	-.2	+.7	+1.0	+.9	+.9	+.4	+.5
October	+.7	+.4	+.2	0	+1.0	+1.1	+.9	+.9	+.7	+.8
November	+.8	+.3	+.2	0	+.7	+1.2	+1.1	+.9	+1.9	+3.1
December	+1.3	+.2	-.1	-.2	+.8	+1.9	+2.0	+2.0	+3.0	+3.2
1968										
January	+1.6	+.1	-.1	-.2	+.7	+2.2	+2.4	+2.2	+3.7	+4.5
February	+.9	-.3	-.5	-.3	+.6	+1.5	+1.6	+1.4	-.3	-2.3
March	+.6	-.5	-.8	-.8	+.4	+1.4	+1.2	+1.2	+.6	-.7
April	+.1	-.5	-.8	-.4	+.5	+.7	+.4	+.5	-1.5	-3.8
May	(5/)	(5/)	-.3	-.2	+.9	+.4	+.1	+.1	-.3	-1.7
June	-.1	0	-.2	0	+.6	+.2	-.1	(6/)	-.8	-1.6
July	+.3	+.2	(5/)	-.2	+.6	+1.0	+.4	+.4	+3.8	+4.8
	Percentage change from same month of preceding year									
1968										
July	+8.6	+.4	-2.0	-2.2	+9.0	+15.3	+13.2	+12.8	+18.2	+13.9

1/ All data subject to revision.
2/ Partly estimated. Does not include Idaho, Indiana, Kentucky, Nebraska, and Puerto Rico for all months, and Nevada beginning January 1968; data not available. Percentage changes based on comparable data.
3/ Represents data for recipients of the specified types of assistance under separate State programs and under State programs for the aged, blind, or disabled, or for such aid and medical assistance for the aged.
4/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance.
5/ Increase of less than 0.05 percent.
6/ Decrease of less than 0.05 percent.

Table 3. Old-age assistance: Recipients and payments to recipients, by State, July 1968[1]

[Excludes vendor payments for medical care and cases receiving only such payments]

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	June 1968 in--		July 1967 in--	
				Number	Amount	Number	Amount
Total 2/	2,020,000	$138,160,000	$68.40	(3/)	+1.0	-2.0	-2.5
Ala.	113,000	6,701,000	59.30	+0.4	+.3	-.3	-1.7
Alaska 4/	1,500	117,000	80.10	0	-.1	+5.0	+18.6
Ariz.	12,900	680,000	52.85	+.1	+4.7	-.3	-7.3
Ark. 4/	61,800	3,381,000	54.70	-.3	-.5	-4.3	-12.3
Calif.	293,000	29,815,000	101.60	+.5	+2.3	+1.1	+1.3
Colo. 2/	38,800	3,002,000	77.45	-.6	-.7	-5.2	-8.8
Conn.	7,400	681,000	91.95	+7.7	+37.1	+1.9	+23.0
Del.	1,900	111,000	59.80	+.5	-4.4	+6.3	-.6
D. C.	2,300	172,000	74.70	+2.2	+1.8	+4.0	+11.4
Fla. 4/	70,500	3,439,000	48.75	-.4	+3.5	-10.0	-11.5
Ga. 4/	88,500	4,593,000	51.90	-.1	-.1	-6.6	-6.1
Guam 5/	240	12,600	52.10	---	---	---	---
Hawaii 4/	1,900	157,000	83.10	+1.7	+3.2	+7.9	+12.6
Idaho	3,500	222,000	64.10	-.5	-.2	-8.1	-11.4
Ill. 4/	37,800	2,304,000	61.00	-.2	+1.1	-2.6	-1.1
Ind.	17,600	822,000	46.70	-.6	-.6	-9.6	-9.4
Iowa	23,500	2,389,000	101.85	-.4	(6/)	-3.2	-3.4
Kans. 4/	16,100	1,421,000	88.05	-.6	(6/)	-7.6	-4.2
Ky. 4/	61,000	3,257,000	53.40	+.3	+.1	+1.3	-3.2
La.	122,000	8,531,000	69.85	-.1	-.1	-1.8	-6.3
Maine 4/	10,100	543,000	53.75	+.2	+.1	-.8	-1.6
Md. 4/	7,700	469,000	60.60	+.5	+1.7	-1.0	-1.5
Mass.	48,000	3,895,000	81.10	(3/)	+.8	-2.9	-1.0
Mich.	38,100	2,576,000	67.65	+.2	+1.1	-4.1	-5.0
Minn.	23,900	1,505,000	63.05	-.9	-.4	-8.6	-5.3
Miss.	71,200	2,564,000	36.00	-.2	-.3	-5.0	-12.4
Mo.	91,800	6,642,000	72.40	-.1	+6.6	+3.2	+9.2
Mont.	3,700	236,000	64.00	+.1	+.1	-5.9	-7.2
Nebr. 4/	8,300	466,000	56.35	-.9	-1.7	-8.5	-7.3
Nev.	2,600	195,000	75.30	+1.5	+2.4	+2.6	+7.2
N. H.	4,100	442,000	107.00	+.1	-.5	-.3	+7.8
N. J.	14,000	1,025,000	73.05	+.1	+.6	+2.1	-.8
N. Mex. 4/	9,600	521,000	54.20	+.6	+.6	+.5	-5.3
N. Y. 4/	76,900	7,271,000	94.55	+1.1	+3.3	+10.9	+21.2
N. C.	37,400	2,520,000	67.35	+.1	+2.6	-5.4	+4.2
N. Dak. 4/	4,100	311,000	75.65	(3/)	+1.1	+6.0	-10.0
Ohio	61,400	3,739,000	60.85	-.1	-.1	-10.0	-21.3
Okla. 4/	77,600	5,545,000	71.45	+.1	-.2	-3.4	-7.5
Oreg.	8,600	443,000	51.50	-2.3	-12.8	-7.9	-22.2
Pa.	42,800	3,018,000	70.55	(3/)	(6/)	-2.3	-8.7
P. R. 4/	21,900	229,000	10.45	-.6	-48.5	-7.2	+8.0
R. I. 4/	4,100	185,000	45.05	-.6	-24.2	-8.4	-28.5
S. C.	19,700	879,000	44.65	-2.2	-5.8	-10.3	-3.1
S. Dak.	4,900	304,000	62.00	-.8	-.2	-12.5	-13.0
Tenn.	50,400	2,479,000	49.20	+.5	+.3	+7.2	-.7
Tex.	228,000	13,847,000	60.60	-.2	+.3	-.3	-2.5
Utah	4,100	201,000	49.40	-.9	-9.6	-10.1	-25.0
Vt. 4/	4,300	290,000	68.15	-.1	+.2	+.6	+4.2
V. I.	370	14,300	38.55	0	-.4	-7.5	-6.5
Va.	10,800	603,000	55.65	(6/)	-.4	-2.3	-.5
Wash.	24,000	1,516,000	63.20	-1.1	+.2	-8.8	-16.1
W. Va.	11,300	704,000	62.45	-.1	+1.4	-4.8	+5.3
Wis.	16,200	1,016,000	62.55	-.3	+.2	-5.3	+2.4
Wyo.	2,000	159,000	77.70	-1.5	-1.9	-1.7	+17.1

1/ All data subject to revision.
2/ Includes 3,600 recipients aged 60-64 in Colorado and payments of $331,000 to these recipients. Such payments were made without Federal participation.
3/ Increase of less than 0.05 percent.
4/ Represents aid to the aged under program for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged.
5/ Data for May; June and July data not reported.
6/ Decrease of less than 0.05 percent.

Table 4. Aid to the blind: Recipients and payments to recipients, by State, July 1968[1]

[Excludes vendor payments for medical care and cases receiving only such payments]

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	June 1968 in--		July 1967 in--	
				Number	Amount	Number	Amount
Total 2/ 3/	81,000	$7,411,000	$91.45	-0.2	+0.3	-2.2	+1.6
Ala.	1,900	133,000	70.05	+1.2	+1.1	+2.8	+2.3
Alaska 4/	95	10,300	107.90	(5/)	(5/)	(5/)	(5/)
Ariz.	640	45,200	70.35	-1.4	-1.2	-10.4	-10.4
Ark. 4/	1,800	128,000	69.35	-.3	-.4	-4.4	-6.6
Calif. 2/	12,500	1,743,000	138.85	+.2	+.7	+1.2	+5.7
Colo.	210	15,200	73.00	+1.5	+2.8	-1.4	-1.0
Conn.	240	20,500	84.30	-.4	+2.1	-5.8	+3.2
Del.	340	30,200	88.95	-.6	-3.2	+.6	+7.5
D. C.	180	16,300	89.90	-.6	-.2	-4.2	-3.1
Fla. 4/	2,400	155,000	64.10	-.2	+2.3	-6.0	-5.2
Ga. 4/	3,200	199,000	62.95	(6/)	+.1	0	+1.3
Guam 7/	6	290	(5/)	---	---	---	---
Hawaii 4/	75	7,700	102.20	(5/)	(5/)	(5/)	(5/)
Idaho	110	8,200	77.30	+2.9	+3.6	0	-1.8
Ill. 4/	1,800	143,000	80.50	-.7	-.4	-6.1	-.6
Ind.	1,400	93,300	64.85	-.2	-.5	-7.4	-6.7
Iowa	1,000	112,000	107.50	-.1	+1.1	-.5	+.3
Kans. 4/	400	35,500	88.70	+1.5	+.9	-1.5	-2.2
Ky. 4/	2,600	184,000	70.40	+.3	+.2	+2.4	+3.3
La.	2,500	191,000	77.30	-.4	-.2	-2.2	-1.3
Maine 4/	210	15,800	75.30	-.9	-.7	-7.9	-5.0
Md. 4/	340	28,400	82.75	-.9	(6/)	+1.2	+6.4
Mass.	2,500	310,000	125.90	-.2	+1.4	+6.2	+12.4
Mich.	1,400	127,000	88.50	+.4	+1.1	-1.4	+2.9
Minn.	820	65,800	80.55	+1.7	+2.2	-2.3	+3.7
Miss.	2,300	105,000	45.35	-.3	-.2	-6.2	-9.1
Mo. 2/	3,900	337,000	86.95	-.3	-.2	-2.2	+6.2
Mont.	160	12,900	79.90	+2.5	+3.1	-8.0	-10.6
Nebr. 4/	350	29,900	85.25	-.8	-.1	-9.8	+.6
Nev.	150	15,800	103.55	+.7	+3.7	+2.7	+20.3
N. H.	240	26,800	114.25	-.4	+4.7	-4.1	+7.0
N. J.	890	79,500	89.30	+.6	+2.3	-1.1	-1.1
N. Mex. 4/	360	27,000	74.25	-1.6	-2.8	+2.2	+1.8
N. Y. 4/	3,300	398,000	121.90	+.8	+2.2	+4.5	+20.8
N. C.	4,600	369,000	79.55	+.3	+1.3	-.4	+6.3
N. Dak. 4/	83	7,100	85.20	(5/)	(5/)	(5/)	(5/)
Ohio	2,800	205,000	72.65	-.7	-.7	-3.9	-2.7
Okla. 4/	1,500	154,000	104.50	-1.6	-1.4	-3.6	-4.2
Oreg.	500	43,600	86.95	-.4	-3.2	+.2	-4.7
Pa. 3/	9,300	1,004,000	108.40	-.7	+.2	-6.1	-7.0
P. R. 4/	790	8,300	10.50	-1.6	-48.7	-31.7	-12.5
R. I. 4/	110	7,500	66.25	-1.7	-8.8	+1.8	-6.0
S. C.	1,900	108,000	57.65	-.3	-2.6	-.4	+3.7
S. Dak.	120	10,000	87.05	+2.7	+4.2	0	+8.1
Tenn.	1,800	121,000	67.35	+.3	+.3	-1.5	-1.7
Tex.	4,200	302,000	72.75	-1.1	-1.0	-1.2	-4.0
Utah	140	8,100	58.45	+1.5	-1.5	-1.4	-14.9
Vt. 4/	100	9,200	87.80	0	+2.2	-.9	+10.5
V. I.	9	380	(5/)	(5/)	(5/)	(5/)	(5/)
Va.	1,100	80,700	74.55	0	+.9	-1.6	+1.4
Wash.	480	41,700	87.70	-1.0	-.6	-7.2	-5.9
W. Va.	600	33,900	56.85	-1.0	-.4	-5.4	-1.8
Wis.	580	45,400	78.65	+.5	+.4	-5.4	-.4
Wyo.	43	3,000	(5/)	(5/)	(5/)	(5/)	(5/)

1/ All data subject to revision.
2/ Data include recipients of payments made without Federal participation and payments to these recipients as follows: California, $30,600 to 180 recipients and Missouri, $62,500 to 700 recipients.
3/ Does not include $583,000 to an estimated 7,800 recipients under State blind pension program in Pennsylvania administered under State law without Federal participation.
4/ Represents aid to the blind under program for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged.
5/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients.
6/ Decrease of less than 0.05 percent.
7/ Data for May; June and July data not reported.

Table 5. Aid to the permanently and totally disabled: Recipients and payments to recipients, by State, July 1968[1]

[Excludes vendor payments for medical care and cases receiving only such payments]

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	June 1968 in--		July 1967 in--	
				Number	Amount	Number	Amount
Total.....	674,000	$55,125,000	$81.80	+0.6	+1.5	+9.0	+15.0
Ala.....	15,900	789,000	49.70	+.9	+1.0	+3.9	+14.0
Alaska 2/.....	470	46,900	100.70	+1.1	(3/)	+30.9	+72.3
Ariz.....	6,100	401,000	65.85	(4/)	+.2	+9.5	+8.5
Ark. 2/.....	11,500	708,000	61.65	+.5	+.5	+2.1	-1.5
Calif.....	126,000	14,951,000	118.70	+1.0	+2.0	+14.2	+17.4
Colo.....	7,200	487,000	67.55	+.5	+1.2	+4.1	+10.1
Conn.....	5,300	578,000	109.85	+7.4	+27.2	+19.4	+48.1
Del.....	1,100	101,000	90.55	+2.0	+1.0	+28.8	+25.9
D. C.....	4,300	370,000	86.45	+1.2	-2.3	+5.6	+8.0
Fla. 2/.....	20,400	1,244,000	61.10	+.1	+2.9	-3.4	-2.1
Ga. 2/.....	29,500	1,810,000	61.30	+.3	+.2	+4.0	+5.9
Guam 5/.....	50	2,900	57.90	---	---	---	---
Hawaii 2/.....	1,600	173,000	110.60	+.4	+2.3	+11.0	+13.2
Idaho.....	2,700	202,000	74.95	-.3	+.1	+5.6	+7.7
Ill. 2/.....	33,500	2,747,000	81.95	+.6	+.4	+10.8	+17.9
Ind.....	3,300	165,000	50.65	+4.6	+4.6	+32.0	+43.4
Iowa.....	2,400	305,000	128.85	+.5	+1.1	+21.2	+22.8
Kans. 2/.....	5,600	666,000	118.25	+.9	+2.0	+1.5	+9.4
Ky. 2/.....	15,400	1,087,000	70.60	+.9	+.8	+13.5	+14.8
La.....	22,400	1,200,000	53.60	+.4	+.6	+.4	+4.0
Maine 2/.....	2,700	208,000	76.35	+.8	+1.1	+12.9	+17.4
Md. 2/.....	13,500	1,059,000	78.40	+2.0	+2.3	+25.3	+29.1
Mass.....	14,900	1,427,000	95.60	+.2	+.9	+9.9	+18.6
Mich.....	19,700	1,720,000	87.15	+.9	+1.1	+19.4	+28.3
Minn.....	8,400	679,000	80.75	+.8	+2.1	+13.5	+24.7
Miss.....	21,800	967,000	44.45	-.1	-.2	+1.5	-2.6
Mo.....	17,300	1,275,000	73.60	+.6	+.8	+5.2	+5.9
Mont.....	1,600	124,000	77.55	+2.0	+2.3	+16.6	+16.7
Nebr. 2/.....	3,400	237,000	69.10	+.3	-1.2	+10.1	+20.5
N. H.....	700	72,400	103.30	+.7	+4.5	+1.4	+16.2
N. J.....	10,000	901,000	90.20	+1.2	+2.0	+8.4	+11.5
N. Mex. 2/....	6,000	412,000	69.00	+1.3	+1.1	+25.1	+22.7
N. Y. 2/.....	42,800	4,680,000	109.40	+.9	+4.5	+13.4	+30.5
N. C.....	23,500	1,702,000	72.50	+.5	+3.2	+1.5	+10.3
N. Dak. 2/....	1,900	161,000	85.40	+1.3	+.8	+5.4	+7.5
Ohio.....	24,900	1,800,000	72.30	+1.6	+1.9	+16.4	+24.3
Okla. 2/.....	19,500	1,842,000	94.45	+.2	(4/)	+1.6	+1.1
Oreg.....	5,100	385,000	75.65	-1.6	-5.0	-.3	-5.3
Pa.....	26,000	1,895,000	73.00	+.3	+.3	+1.6	+.3
P. R. 2/.....	12,500	132,000	10.55	+.3	-48.2	-12.1	+21.1
R. I. 2/.....	3,500	256,000	73.25	+.2	-10.6	+10.5	+5.0
S. C.....	9,100	467,000	51.25	-1.3	-4.3	-1.8	+4.3
S. Dak.....	1,300	86,700	65.95	+.2	-1.6	-.9	+1.5
Tenn.....	18,800	1,229,000	65.50	+1.0	+1.1	+14.6	+14.6
Tex.....	15,500	947,000	61.30	-1.0	+7.8	+34.4	+35.1
Utah.....	3,800	223,000	58.15	-.3	-5.1	+12.6	+4.8
Vt. 2/.....	1,500	127,000	83.50	+2.2	+3.8	+16.4	+17.2
V. I.....	65	2,700	41.40	(6/)	(6/)	(6/)	(6/)
Va.....	7,100	475,000	66.75	+.1	-.1	+1.8	+5.3
Wash.....	10,000	831,000	83.35	-3.6	+1.3	+4.9	+14.9
W. Va.....	6,200	342,000	55.15	+.5	+.8	+7.2	+12.7
Wis.....	5,700	369,000	64.15	+2.0	+5.3	+28.5	+32.8
Wyo.....	840	60,200	71.60	+.7	+1.6	+5.5	+9.3

1/ All data subject to revision.
2/ Represents aid to the permanently and totally disabled under program for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged.
3/ Increase of less than 0.05 percent.
4/ Decrease of less than 0.05 percent.
5/ Data for May; June and July data not reported.
6/ Percentage change not computed on base of fewer than 100 recipients.

Table 6. Aid to families with dependent children: Recipients and payments to recipients, by State, July 1968[1]

/Excludes vendor payments for medical care and cases receiving only such payments/

State	Number of families	Number of recipients		Payments to recipients			Percentage change from--			
					Average per--		June 1968 in--		July 1967 in--	
		Total 2/	Children	Total amount	Family	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total 3/..	1,397,000	5,633,000	4,226,000	$237,502,000	$170.00	$42.15	+0.4	+1.2	+13.2	+28.1
Ala.....	22,000	92,800	74,000	1,407,000	63.95	15.15	+2.6	+2.8	+30.3	+55.1
Alaska.....	1,600	5,700	4,400	220,000	136.15	38.35	-.7	-.2	+14.1	+25.4
Ariz.....	10,200	42,800	32,500	1,233,000	121.50	28.80	-1.6	-1.7	-.4	-.1
Ark.....	9,200	37,900	28,700	722,000	78.10	19.05	-2.8	-3.9	+3.5	+1.0
Calif. 3/....	210,000	814,000	592,000	37,930,000	180.65	46.60	-.5	+1.8	+7.2	+13.7
Colo. 3/.....	14,300	54,000	41,200	2,159,000	150.75	39.95	-.8	-.2	+1.3	+8.0
Conn. 3/.....	17,300	66,600	49,700	3,775,000	218.60	56.65	+1.5	+10.6	+17.0	+36.5
Del. 3/.....	4,200	17,200	13,000	554,000	131.25	32.25	+.3	+.2	+19.0	+20.7
D. C. 3/.....	5,900	26,800	21,400	1,049,000	178.90	39.15	+1.2	+2.0	+10.4	+14.8
Fla.....	38,600	152,000	121,000	3,195,000	82.80	21.00	+1.8	+41.2	+6.6	+46.7
Ga.....	29,800	117,000	90,100	2,914,000	97.80	24.85	+1.9	+1.5	+22.0	+19.0
Guam 4/.....	210	1,100	960	40,200	188.95	35.00	---	---	---	---
Hawaii 3/....	4,800	19,700	14,500	978,000	203.10	49.75	-.2	+11.8	+6.2	+16.7
Idaho.....	3,200	12,100	8,700	566,000	177.10	46.75	-.5	-.5	+7.0	+7.1
Ill. 3/.....	65,100	295,000	230,000	12,941,000	198.75	43.85	(5/)	-.2	+15.0	+20.2
Ind.....	12,800	53,300	40,200	1,719,000	134.10	32.25	+.2	-.9	+8.2	+13.8
Iowa.....	13,600	52,600	38,400	2,590,000	190.50	49.20	+1.0	+.9	+17.5	+34.1
Kans. 3/.....	10,000	41,300	32,100	1,866,000	186.50	45.20	+.6	+3.4	+11.2	+16.5
Ky.....	28,300	110,000	80,000	3,147,000	111.30	28.50	+1.1	+1.2	+11.9	+13.9
La.....	32,600	143,000	111,000	3,390,000	103.85	23.70	+1.7	+1.8	+23.1	+22.1
Maine.....	6,000	22,300	16,300	666,000	110.50	29.80	+.1	+.4	+7.9	+7.9
Md. 3/.....	28,000	112,000	86,200	4,400,000	157.00	39.45	+.3	+1.6	+10.8	+13.5
Mass. 3/.....	41,000	150,000	112,000	6,710,000	212.55	57.95	+.9	+4.7	+20.9	+31.0
Mich. 3/.....	48,300	197,000	148,000	8,887,000	184.10	45.10	+.1	(5/)	+17.0	+24.1
Minn.....	17,000	61,700	47,700	3,368,000	198.25	54.55	+.1	+1.2	+9.3	+20.5
Miss.....	25,300	103,000	84,700	874,000	34.55	8.50	+.3	+.5	+9.8	+12.2
Mo.....	28,000	116,000	88,900	3,115,000	111.40	26.95	-.6	+8.8	+5.7	+14.5
Mont.....	2,600	9,800	7,500	365,000	138.90	37.10	-1.0	-.6	+5.6	+3.3
Nebr. 3/.....	6,100	24,300	18,700	899,000	147.85	37.00	-.7	-.3	+15.4	+17.5
Nev.....	2,300	8,700	6,700	267,000	115.90	30.50	+2.2	+.9	+27.2	+23.0
N. H.....	1,500	6,300	4,700	271,000	176.85	43.30	+1.1	+1.0	+12.8	+22.9
N. J.....	40,200	160,000	121,000	9,302,000	231.45	58.30	+.5	+.7	+19.0	+23.7
N. Mex.....	10,300	41,600	31,400	1,291,000	125.30	31.05	+.5	+1.2	+14.2	+15.6
N. Y. 3/.....	224,000	874,000	640,000	62,031,000	277.20	71.00	+2.4	+1.3	+23.1	+60.9
N. C.....	25,600	104,000	78,500	2,831,000	110.70	27.30	-3.2	+2.1	-1.2	+8.2
N. Dak.....	2,500	9,800	7,500	468,000	188.10	47.95	-.8	-.8	+7.7	+12.4
Ohio 3/.....	56,800	231,000	172,000	8,669,000	152.75	37.60	(5/)	+.2	+15.1	+29.0
Okla. 3/.....	22,900	88,400	66,500	3,052,000	133.35	34.50	-.3	(6/)	+2.1	+2.3
Oreg. 3/.....	10,100	37,900	27,100	1,537,000	151.90	40.55	-4.2	-3.5	+5.2	+5.6
Pa. 3/.....	73,700	307,000	225,000	12,132,000	164.70	39.45	+.5	+2.9	+15.6	+22.7
P. R.....	35,600	174,000	132,000	1,248,000	35.05	7.15	+.5	-55.4	-3.1	+63.0
R. I. 3/.....	8,000	30,800	22,600	1,452,000	181.85	47.15	-.8	-2.1	+9.3	+22.8
S. C.....	7,900	30,800	24,700	567,000	72.05	18.45	-.3	-.4	+25.2	+33.5
S. Dak.....	3,700	13,700	10,300	608,000	164.70	44.25	-.8	-1.2	+1.0	+6.5
Tenn.....	25,400	100,000	77,300	2,620,000	103.25	26.10	+.1	-1.3	+10.2	+7.6
Tex.....	30,200	140,000	108,000	2,864,000	95.00	20.45	-.6	-.4	+32.9	+27.9
Utah 3/.....	6,700	26,300	18,900	1,020,000	151.85	38.80	-2.5	-1.0	+12.1	+12.3
Vt. 3/.....	2,500	9,400	6,800	442,000	175.20	47.10	+1.9	+2.6	+31.1	+47.7
V. I.....	400	1,600	1,300	47,200	117.75	29.85	-2.5	+1.2	-5.8	+14.3
Va.....	14,700	60,600	46,600	1,888,000	128.60	31.15	(6/)	+.7	+12.2	+19.7
Wash. 3/.....	18,100	65,900	47,400	3,203,000	177.00	48.60	+.7	+2.7	+13.1	+16.3
W. Va. 3/....	19,300	86,300	60,600	2,213,000	114.70	25.65	-2.1	-1.9	-10.8	-9.0
Wis. 3/.....	18,100	70,200	52,900	3,634,000	201.00	51.80	+.8	+3.8	+28.9	+52.9
Wyo.....	1,200	4,400	3,400	170,000	142.00	38.25	-3.1	-2.7	+3.3	+5.1

1/ All data subject to revision.
2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance.
3/ Includes data on unemployed-parent segment; see table 7.
4/ Data for May; June and July data not reported.
5/ Increase of less than 0.05 percent.
6/ Decrease of less than 0.05 percent.

Table 7. Aid to families with dependent children, unemployed-parent segment: Recipients and payments to recipients, by State, July 1968[1]

/Excludes vendor payments for medical care and cases receiving only such payments/

State	Number of families	Number of recipients		Payments to recipients			Percentage change from--			
					Average per--		June 1968 in--		July 1967 in--	
		Total 2/	Children	Total	Family	Recipients	Number of recipients	Amount	Number of recipients	Amount
Total....	60,200	329,000	222,000	$14,029,000	$233.10	$42.65	-5.4	-2.6	-4.8	+12.1
Calif.....	21,500	119,000	79,400	4,547,000	211.35	38.05	-6.5	-4.2	-7.2	-.8
Colo.....	780	4,500	3,000	187,000	241.65	41.60	-10.9	-9.9	-37.7	-31.7
Conn.....	290	1,700	1,100	84,700	292.10	50.40	-4.2	-3.2	-49.0	-32.5
Del.....	150	900	690	28,300	192.20	31.40	-8.4	-8.3	-26.7	-22.0
Hawaii.....	300	1,800	1,200	73,300	244.50	41.15	-19.2	-20.4	-15.1	-10.6
Ill.....	3,100	19,700	13,600	800,000	257.80	40.65	-6.3	-7.1	+4.3	+9.1
Kans.....	270	1,700	1,100	66,300	244.80	39.75	-2.7	+2.0	+32.6	+48.9
Md.....	180	1,000	790	35,700	193.10	34.10	-6.3	-9.6	-45.7	-43.8
Mass.....	640	3,800	2,600	200,000	310.50	53.20	-1.6	-.4	+6.8	+15.4
Mich.....	1,700	10,500	7,200	430,000	258.35	41.05	-8.2	-5.9	-1.8	+2.3
Nebr.....	82	490	340	16,500	200.80	33.65	-17.7	-18.4	+25.1	+43.4
N. Y.....	16,300	79,500	55,200	4,873,000	298.55	61.25	+.7	+3.2	+9.2	+49.9
Ohio.....	2,600	16,000	10,800	569,000	216.35	35.60	-8.3	-8.1	-8.0	+5.1
Okla.....	520	3,200	2,100	103,000	197.55	32.75	-6.5	-7.2	-6.7	-5.9
Oreg.....	720	3,600	2,300	140,000	195.60	39.20	-37.8	-37.3	-9.8	+1.5
Pa.....	3,100	16,600	10,600	528,000	172.50	31.90	-1.5	+6.3	+12.7	+27.1
R. I.....	300	1,700	1,200	68,300	227.65	39.60	-21.3	-21.2	-9.2	+7.7
Utah.....	980	5,400	3,700	166,000	168.45	30.65	-10.4	-6.5	+14.6	+50.0
Vt.....	2	7	4	490	(3/)	(3/)	---	---	---	---
Wash.....	440	2,200	1,400	92,500	209.20	42.70	-9.1	-5.4	-52.1	-52.0
W. Va.....	5,400	30,600	20,400	801,000	149.00	26.20	-5.8	-5.8	-23.9	-22.2
Wis.....	850	4,800	3,200	219,000	257.65	45.85	-1.4	+4.0	+71.2	+90.8

1/ Data for this segment of the program, shown separately here, are included in data for the total program. All data subject to revision.
2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance.
3/ Average payment not computed on base of fewer than 50 families; percentage change on fewer than 100 recipients.

Table 8. General assistance: Recipients and payments to recipients for selected cities, July 1968

/Excludes vendor payments for medical care and cases receiving only such payments/

City	Number of--		Payments to recipients			Percentage change from--			
				Average per--		June 1968 in--		July 1967 in--	
	Cases	Recipients	Total amount	Case	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total, 15 cities 1/..	157,000	303,000	$18,840,000	$120.25	$62.10	+7.9	+10.0	+11.6	+23.6
Baltimore.....	5,400	6,500	469,000	86.15	72.00	-1.4	-.8	-12.4	-13.6
Boston.....	4,400	7,000	518,000	117.25	74.15	+8.9	+14.4	+64.5	+62.3
Buffalo 2/.....	4,200	6,200	438,000	103.05	70.40	+2.5	+5.9	(3/)	(3/)
Chicago.....	16,700	34,200	1,910,000	114.20	55.90	+6.3	+6.5	+12.9	+29.1
Cincinnati 2/.....	5,300	17,400	410,000	77.35	23.60	+4.9	+7.2	+7.7	+9.4
Cleveland 2/.....	7,200	18,600	657,000	91.40	35.35	+5.8	+13.0	-8.7	+4.5
Detroit.....	(1/)	(1/)	(1/)	---	---	---	---	---	---
District of Columbia....	950	1,000	82,000	85.95	78.90	+2.7	+11.0	+3.1	+.9
Los Angeles 2/.....	19,000	34,000	1,185,000	62.30	34.80	+35.0	+15.8	+21.5	+5.5
Milwaukee 2/.....	3,000	7,000	563,000	186.30	80.35	+39.0	+148.1	+13.6	+167.3
Minneapolis.....	1,800	4,000	155,000	86.35	39.05	+12.3	+8.4	-8.6	+38.9
New Orleans.....	1,100	1,100	57,900	54.55	50.55	+2.0	+3.3	+31.2	+32.5
New York.....	78,900	155,000	11,732,000	148.65	75.90	+4.6	+7.6	(3/)	(3/)
Philadelphia.....	(1/)	(1/)	(1/)	---	---	---	---	---	---
Pittsburgh.....	(1/)	(1/)	(1/)	---	---	---	---	---	---
Rochester.....	830	2,300	87,300	104.65	37.80	+6.4	+.8	(3/)	(3/)
St. Louis.....	2,000	2,300	127,000	64.30	54.45	+7.5	+.4	+5.6	+8.1
San Francisco.....	5,800	7,300	451,000	78.15	61.85	-7.8	+14.6	+53.0	+53.2

1/ Data not reported for Detroit, Philadelphia and Pittsburgh. Percentage changes based on comparable data.
2/ Data for county in which city is located.
3/ Data not reported for Buffalo, New York, and Rochester for July 1967.

Table 9. General assistance: Recipients and payments to recipients, by State, July 1968[1]

[Excludes vendor payments for medical care and cases receiving only such payments]

State	Number of--		Payments to recipients			Percentage change from--			
				Average per--		June 1968 in--		July 1967 in--	
	Cases	Recipients	Total amount	Case	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total 2/	369,000	773,000	$35,209,000	$95.35	$45.55	+4.8	+6.9	+13.9	+36.4
Ala.	75	75	1,000	13.65	13.65	(3/)	(3/)	(3/)	(3/)
Alaska	150	200	10,000	68.30	48.95	-52.9	+9.1	-73.6	-32.1
Ariz.	1,600	4,500	87,100	53.60	19.20	-19.3	-16.8	+22.0	+10.1
Ark.	240	860	3,600	15.00	4.25	+27.8	+37.5	-26.5	-19.0
Calif.	34,600	57,300	2,429,000	70.25	42.45	+19.5	+10.9	+19.4	+14.6
Colo.	1,100	3,400	47,300	43.15	13.90	+7.5	+20.0	+10.9	+23.1
Conn. 4/	5,800	16,700	501,000	86.95	30.00	+4.9	+1.2	+23.9	+40.1
Del.	1,900	4,100	113,000	60.40	27.80	+.6	-.7	+40.7	+37.4
D. C.	950	1,000	82,000	85.95	78.90	+2.7	+11.0	+3.1	+.9
Fla. 4/	8,000	(5/)	244,000	---	---	---	---	---	---
Ga.	2,200	5,600	88,000	40.50	15.70	+2.1	+4.2	+7.7	+19.3
Guam 6/	46	60	2,800	(3/)	46.40	---	---	---	---
Hawaii	1,500	2,800	170,000	110.80	59.90	+16.9	+22.3	+29.5	+38.0
Ill.	25,300	55,000	2,427,000	96.00	44.15	+5.6	+5.8	+8.2	+22.5
Iowa 4/	3,200	7,700	132,000	---	---	---	---	---	---
Kans.	2,900	5,900	245,000	85.20	41.85	+2.0	+2.4	+14.8	+15.4
La.	6,600	7,200	336,000	51.30	46.95	+1.6	+1.5	+9.4	+11.0
Maine	2,000	6,300	78,700	39.15	12.40	-11.1	-11.3	-2.1	-2.8
Md.	6,400	7,700	548,000	85.55	71.50	-.8	-.4	-10.2	-10.9
Mass.	10,000	20,900	1,006,000	100.15	48.20	+.6	+9.1	+19.8	+35.7
Mich.	22,600	70,200	2,445,000	108.30	34.85	+1.4	+13.4	+30.9	+43.7
Minn.	6,600	19,000	625,000	94.85	32.90	+9.0	+16.5	+21.2	+45.4
Miss.	1,300	1,600	24,400	18.75	15.10	+5.1	-2.7	-.2	+1.6
Mo.	10,000	12,500	645,000	64.35	51.65	-.3	-1.7	+2.9	+1.3
Mont.	860	2,700	52,900	61.80	19.65	-11.5	-.7	+14.2	+22.5
N. H.	660	2,000	44,500	67.05	21.75	-2.8	+4.4	-6.7	-2.5
N. J. 7/	12,200	36,400	1,485,000	121.30	40.85	+3.6	-1.6	+6.0	+6.6
N. Mex.	240	560	9,400	39.85	16.90	-11.2	+10.3	-29.6	-57.6
N. Y.	100,000	205,000	14,170,000	141.15	69.05	+3.9	+6.9	+37.2	+83.3
N. C.	1,600	3,900	43,100	27.65	11.10	-.4	-8.3	-2.0	+9.3
N. Dak.	200	690	8,900	45.70	13.00	-22.5	-25.7	-27.4	-23.7
Ohio	24,200	64,900	2,379,000	98.35	36.65	+7.2	-11.2	-12.6	+.2
Okla.	1,100	(5/)	20,600	18.45	---	---	+12.0	---	-69.5
Oreg.	2,300	(5/)	123,000	53.90	---	---	+10.3	---	-44.7
Pa.	34,600	44,600	2,585,000	74.70	57.90	+2.5	+1.7	+24.5	+22.2
R. I.	4,000	11,300	299,000	73.95	26.35	-2.9	-1.0	+23.3	+28.5
S. C.	740	880	29,000	38.95	33.10	-2.3	-1.7	-.8	+3.3
S. Dak.	210	740	9,500	44.90	12.75	+.3	+11.7	-27.2	-6.4
Tenn.	1,300	3,400	41,700	31.95	12.35	+3.3	-5.6	-24.1	-19.7
Tex. 4/	9,800	(5/)	228,000	---	---	---	---	---	---
Utah	1,200	1,400	99,000	82.05	70.95	-5.9	-2.5	+44.2	+75.7
Vt. 4/	400	(5/)	13,000	---	---	---	---	---	---
V. I.	150	170	6,500	42.05	38.55	-1.8	-1.0	-2.9	-.8
Va.	3,600	7,300	214,000	58.80	29.40	-6.9	+.8	+8.1	+29.8
Wash.	8,100	14,600	750,000	92.15	51.30	+15.9	+12.4	+35.4	+44.2
W. Va.	1,700	3,100	82,700	47.30	26.60	+21.4	+6.3	+7.5	+4.8
Wis.	5,300	13,600	395,000	74.90	29.05	+29.3	+18.6	+14.4	-23.0
Wyo.	180	540	13,000	72.00	23.80	+3.8	+1.6	-37.7	-24.5

1/ All data subject to revision.
2/ Partly estimated; does not represent sum of State figures because totals exclude for New Jersey an estimated number of cases and persons receiving only medical care, hospitalization, and/or burial and payments for such services; recipient count includes an estimate for States not reporting such data. Excludes Idaho, Indiana, Kentucky, Nebraska, Nevada, and Puerto Rico; data not available.
3/ Average payment not computed on base of fewer than 50 cases; percentage change on fewer than 100 recipients.
4/ Estimated.
5/ Data not available.
6/ Data for May; June and July data not reported.
7/ Includes an unknown number of cases and persons receiving only medical care, hospitalization, and/or burial and payments for such services.

Table 10. Amount of vendor payments for medical care for recipients of public assistance, by program and State, July 1968[1]

State	Total	Percentage change from--		Medical assistance	Medical assistance for the aged	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled	Aid to families with dependent children	General assistance 2/
		June 1968	July 1967							
Total	3/ $328,334,000	-6.0	+48.4	3/ $303,789,000	$5,961,000	$8,354,000	$180,000	$2,954,000	$2,275,000	$4,821,000
Ala.	1,542,000	-.6	+25.3	---	460	1,394,000	6,300	141,000	---	---
Alaska 4/	115,000	-40.4	+77.2	---	---	43,500	1,000	35,100	---	35,600
Ariz.	154,000	+.7	+6.9	---	740	153,000	---	---	---	---
Ark. 4/	1,801,000	+.6	+9.8	---	353,000	959,000	23,800	363,000	102,000	---
Calif.	49,700,000	-21.0	+12.1	49,700,000	---	---	---	---	---	---
Colo.	2,228,000	-2.4	+13.0	---	5/ 1,222,000	500,000	6,300	217,000	240,000	43,100
Conn.	5,316,000	-16.2	+82.4	5,316,000	---	---	---	---	---	---
Del.	345,000	+44.4	+136.3	345,000	---	---	---	---	---	---
D. C.	681,000	+477.1	+192.3	---	659,000	3,000	91	11,000	6,000	1,900
Fla.	1,984,000	-9.9	-.1	---	---	1,564,000	19,100	254,000	147,000	---
Ga.	5,050,000	-6.6	+163.6	5,050,000	---	---	---	---	---	---
Guam 6/	1,900	---	---	1,900	---	---	---	---	---	---
Hawaii	792,000	+16.8	+72.9	714,000	---	---	---	---	---	77,800
Idaho	305,000	-44.5	-31.6	305,000	---	---	---	---	---	---
Ill.	14,027,000	-.9	+49.3	12,504,000	---	---	---	---	---	1,523,000
Ind.	2,801,000	+.1	+27.1	---	438,000	1,376,000	66,000	462,000	459,000	---
Iowa	2,814,000	+29.7	+33.6	2,716,000	---	---	---	---	---	7/ 97,700
Kans.	1,607,000	-58.0	-19.7	1,607,000	---	---	---	---	---	---
Ky.	4,198,000	+.5	+122.6	4,198,000	---	---	---	---	---	---
La.	3,677,000	-16.5	+34.8	3,600,000	---	---	---	---	---	77,200
Maine	725,000	-41.8	-4.4	642,000	---	---	---	---	---	82,800
Md.	4,786,000	-47.9	+25.9	4,786,000	---	---	---	---	---	---
Mass.	19,210,000	-12.4	+60.2	18,921,000	---	---	---	---	---	289,000
Mich.	15,[illegible]2,000	-9.2	+126.9	15,751,000	---	---	---	---	---	151,000
Minn.	7,923,000	+1.7	+27.0	7,615,000	---	---	---	---	---	308,000
Miss.	431,000	+30.2	+73.8	---	---	265,000	2,000	26,300	138,000	---
Mo.	3,719,000	-14.2	+183.7	3,719,000	---	---	---	---	---	---
Mont.	852,000	0	+54.9	562,000	---	---	---	---	---	290,000
Nebr.	1,672,000	-5.5	+54.5	1,672,000	---	---	---	---	---	---
Nev.	459,000	-23.6	+152.2	459,000	---	---	---	---	---	---
N. H. 6/	330,000	---	---	330,000	---	---	---	---	---	---
N. J.	4,355,000	-2.2	-18.9	---	5/ 2,938,000	209,000	15,100	411,000	595,000	187,000
N. Mex.	1,386,000	-12.2	+143.6	1,369,000	---	---	---	---	---	17,200
N. Y.	91,289,000	+3.5	+69.5	91,289,000	---	---	---	---	---	---
N. C.	1,637,000	-9.2	-2.5	---	96,600	219,000	22,300	783,000	434,000	81,800
N. Dak.	738,000	-12.5	-16.5	732,000	---	---	---	---	---	5,900
Ohio	9,620,000	+21.2	+84.3	8,823,000	---	---	---	---	---	797,000
Okla.	5,961,000	-5.9	+33.7	5,961,000	---	---	---	---	---	---
Oreg.	1,604,000	+1.6	+46.4	1,521,000	---	---	---	---	---	83,100
Pa.	16,795,000	+19.2	+51.8	16,795,000	---	---	---	---	---	---
P. R.	4,075,000	+27.8	+101.0	4,075,000	---	---	---	---	---	---
R. I.	2,189,000	-14.7	+32.0	2,109,000	---	---	---	---	---	79,900
S. C.	948,000	+13.8	+58.0	931,000	---	---	---	---	---	16,500
S. Dak.	731,000	-2.3	+31.7	655,000	---	---	---	---	---	76,400
Tenn.	1,487,000	+3.3	+22.4	---	175,000	1,159,000	1,800	69,400	81,500	---
Tex.	12,573,000	+6.6	+194.0	12,573,000	---	---	---	---	---	---
Utah	893,000	+3.7	+25.2	893,000	---	---	---	---	---	380
Vt.	682,000	-31.5	+66.7	682,000	---	---	---	---	---	---
V. I.	(3/)	---	---	(3/)	---	---	---	---	---	---
Va.	900,000	-6.5	+32.9	---	78,100	510,000	15,900	181,000	72,300	42,600
Wash.	4,387,000	+1.2	-22.3	4,346,000	---	---	---	---	---	41,200
W. Va.	989,000	-13.1	+120.3	989,000	---	---	---	---	---	---
Wis.	9,812,000	-12.5	+38.4	9,443,000	---	---	---	---	---	369,000
Wyo.	135,000	-22.0	+36.3	89,100	---	---	---	---	---	45,700

1/ Amounts represent primarily bills paid during the month and therefore are subject to fluctuations unrelated to provisions of medical services. All data subject to revision.
2/ Data incomplete for general assistance. Some States do not report these data and for some the data represent only partial reporting.
3/ Data not reported by Virgin Islands.
4/ Except for aid to families with dependent children and general assistance, data represent payments for recipients of the specified types of assistance under program for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged.
5/ Excludes small amount of money payments not subject to Federal participation.
6/ Data for May; June and July.
7/ Partly estimated.

Table 11. Amount of medical vendor payments for public assistance programs under the Social Security Act, by form of payment and State, July 1968[1]

State	Total	Form of medical vendor payments	
		Payments to vendors directly or through fiscal agent	Premium or per capita payments 2/
Total 3/	$323,514,000	$306,770,000	$16,746,000
Title XIX States 3/	303,789,000	290,665,000	13,127,000
Other States	19,725,000	16,105,000	3,619,000
	Title XIX States		
Calif	49,700,000	48,440,000	1,260,000
Conn	5,316,000	5,283,000	33,400
Del	345,000	338,000	7,900
Ga	5,050,000	5,050,000	---
Guam 4/	1,900	560	1,400
Hawaii	714,000	714,000	---
Idaho	305,000	281,000	24,100
Ill	12,504,000	12,504,000	---
Iowa	2,716,000	2,622,000	94,100
Kans	1,607,000	1,514,000	92,900
Ky	4,198,000	3,942,000	256,000
La	3,600,000	3,600,000	---
Maine	642,000	592,000	50,400
Md	4,786,000	4,786,000	---
Mass	18,921,000	18,919,000	1,900
Mich	15,751,000	15,751,000	---
Minn	7,615,000	7,515,000	100,000
Mo	3,719,000	3,341,000	378,000
Mont	562,000	547,000	15,400
Nebr	1,672,000	1,621,000	51,400
Nev	459,000	459,000	---
N. H. 4/	330,000	313,000	17,200
N. Mex	1,369,000	1,369,000	---
N. Y	91,289,000	91,066,000	223,000
N. Dak	732,000	686,000	2/ 46,300
Ohio	8,823,000	8,823,000	---
Okla	5,961,000	1,345,000	2/ 4,616,000
Oreg	1,521,000	1,521,000	---
Pa	16,795,000	15,984,000	811,000
P. R	4,075,000	4,075,000	---
R. I	2,109,000	2,109,000	---
S. C	931,000	839,000	91,600
S. Dak	655,000	635,000	19,900
Tex	12,573,000	7,840,000	2/ 4,733,000
Utah	893,000	893,000	---
Vt	682,000	665,000	17,800
Wash	4,346,000	4,190,000	2/ 156,000
W. Va	989,000	989,000	---
Wis	9,443,000	9,415,000	28,400
Wyo	89,100	89,100	---
	Other States		
Ala	1,541,000	1,541,000	---
Alaska	79,600	79,600	---
Ariz	154,000	109,000	44,400
Ark	1,800,000	1,549,000	251,000
Colo	2,185,000	1,804,000	2/ 381,000
D. C	679,000	679,000	---
Fla	1,984,000	1,696,000	288,000
Ind	2,802,000	2,496,000	2/ 306,000
Miss	431,000	431,000	---
N. J	4,169,000	4,107,000	62,000
N. C	1,556,000	681,000	2/ 875,000
Tenn	1,486,000	176,000	2/ 1,311,000
Va	858,000	757,000	2/ 101,000

1/ All data subject to revision.
2/ Entries represent premium payments into the Social Security Administration system for Supplementary Medical Insurance except for premium payments into an agency pooled fund by North Carolina-$875,000; Oklahoma-$4,301,000; Tennessee-$1,111,000; and premium payments to health-insuring agencies by Colorado-$232,000; Indiana-$228,000; North Dakota-$29,800; Texas-$3,821,000; Virginia-$57,400; and Washington-$11,000.
3/ Data not reported for Virgin Islands.
4/ Data for May; June and July data not reported.

Table 12. Proportion of population receiving public assistance money payments (recipient rates), by State, June 1968[1]

[Excludes recipients receiving only vendor payments for medical care. All data subject to revision]

State	All recipients per 1,000 population		Recipients of old-age assistance per 1,000 population age 65 and over	Recipients of aid to the blind per 100,000 population age 18 and over	Recipients of aid to the permanently and totally disabled per 1,000 population aged 18-64	Children receiving aid to families with dependent children		Recipients of general assistance per 1,000 population under age 65
	Including General assistance	Excluding General assistance				Per 1,000 population under age 18	Per 1,000 population under age 21	
U. S. average...	45	42	105	63	6.2	58	51	2/ 4.6
Ala.....	62	62	378	85	8.2	55	48	(3/)
Alaska.....	34	32	182	76	4.0	38	34	1.9
Ariz.....	42	39	98	66	7.1	51	45	3.7
Ark.....	57	57	286	144	10.7	41	36	.4
Calif.....	69	66	175	4/ 104	12.0	88	78	2.8
Colo.....	52	51	201	16	6.7	56	49	1.7
Conn.....	32	26	25	13	3.0	48	43	6.0
Del.....	47	39	45	106	3.9	65	58	8.4
D. C.....	43	42	32	36	9.6	75	68	1.4
Fla.....	5/ 40	40	88	61	6.4	57	51	(5/)
Ga.....	54	53	260	114	12.2	52	45	1.3
Guam.....	18	18	127	15	1.3	23	20	.8
Hawaii.....	35	32	43	17	4.1	48	43	3.6
Idaho.....	5/ 26	26	53	24	7.3	33	29	(5/)
Ill.....	38	34	33	25	5.6	60	53	5.3
Ind.....	5/ 15	15	37	45	1.1	22	19	(5/)
Iowa.....	31	29	68	59	1.6	40	35	2.8
Kans.....	30	28	62	27	4.6	40	35	2.9
Ky.....	5/ 59	59	191	129	8.9	69	60	(5/)
La.....	80	78	420	112	11.6	74	65	2.1
Maine.....	44	37	91	34	5.3	47	41	8.3
Md.....	36	36	28	15	6.5	62	55	2.3
Mass.....	44	40	79	69	5.1	60	53	4.3
Mich.....	37	29	48	26	4.2	45	40	8.7
Minn.....	31	26	60	35	4.4	35	31	5.4
Miss.....	86	85	343	166	18.3	92	80	.7
Mo.....	53	50	166	4/ 129	7.0	57	50	3.1
Mont.....	27	22	55	37	4.4	29	26	4.9
Nebr.....	5/ 26	26	47	39	4.7	37	32	(5/)
Nev.....	5/ 25	25	98	56	---	38	34	(5/)
N. H.....	19	16	55	52	1.8	19	17	3.4
N. J.....	31	26	21	19	2.5	51	45	6/ 5.5
N. Mex.....	58	57	147	65	11.8	72	64	.7
N. Y.....	65	54	40	27	4.1	105	92	12.2
N. C.....	35	34	97	146	8.4	44	38	.8
N. Dak.....	27	26	65	22	5.9	32	28	1.6
Ohio.....	36	30	61	42	4.2	45	40	6.3
Okla.....	5/ 76	76	279	92	14.4	79	70	(5/)
Oreg.....	5/ 27	27	42	38	4.6	42	36	(5/)
Pa.....	37	33	35	119	3.9	58	51	4.2
P. R.....	5/ 77	77	143	55	9.5	104	91	(5/)
R. I.....	57	44	42	20	7.2	76	67	14.9
S. C.....	24	24	111	119	6.6	24	21	.4
S. Dak.....	32	31	62	28	4.0	42	37	1.3
Tenn.....	44	43	142	70	8.4	56	49	.9
Tex.....	5/ 36	36	248	63	2.7	26	23	(5/)
Utah.....	36	34	58	23	7.3	45	40	1.5
Vt.....	5/ 36	36	93	39	6.6	44	39	(5/)
V. I.....	36	33	116	26	2.1	49	43	2.9
Va.....	20	18	32	39	2.9	28	25	1.9
Wash.....	35	31	77	23	5.9	42	36	4.4
W. Va.....	60	59	61	50	6.1	102	87	1.6
Wis.....	24	22	36	22	2.5	34	30	2.8
Wyo.....	26	24	69	22	5.1	30	26	1.9

1/ Based on civilian population as of July 1, 1968; estimated by the Bureau of the Census.
2/ Based on data for 43 States. See footnote 5.
3/ Less than 0.05.
4/ Includes recipients of payments made without Federal participation. Recipient rates excluding these recipients are as follows: California, 102 and Missouri 106.
5/ Number of persons aided under General assistance program not currently available.
6/ Includes an unknown number of persons receiving medical care, hospitalization, and burial only.

Table 13. Old-age, survivors, disability, and health insurance, summary benefit data, July 1968

CASH BENEFITS AWARDED AND IN CURRENT-PAYMENT STATUS

Type of beneficiary	Benefit awards		Benefits in current-payment status			Amount of benefits paid 1/ (in thousands)
	Number	Average amount	Number	Average amount	Monthly rate (in thousands)	
Total monthly beneficiaries	319,979	---	24,208,606	---	$2,022,805	$2,101,258
Retired workers and dependents	149,981	---	15,391,570	---	1,358,466	1,377,908
Retired workers	105,479	$102.94	12,234,228	$98.41	1,204,026	1,213,579
Wives and husbands 2/	29,142	48.58	2,638,002	51.05	134,676	142,578
Children 3/	15,360	40.13	519,340	38.06	19,764	21,751
Disabled workers and dependents	66,730	---	2,278,176	77.71	177,026	197,185
Disabled workers	30,817	115.34	1,258,402	111.68	140,538	154,924
Wives and husbands 2/	8,370	37.90	247,785	38.37	9,508	11,211
Children 3/	27,543	33.81	771,989	34.95	26,981	31,050
Survivors of deceased workers	96,782	---	5,841,795	---	459,967	498,192
Widowed mothers	10,592	75.71	498,092	74.69	37,202	41,073
Children 3/	52,523	66.35	2,448,880	70.83	173,461	189,422
Widows and widowers 4/	33,472	88.22	2,862,575	86.10	246,468	264,555
Parents	195	95.24	32,248	87.96	2,836	3,142
Persons with special age-72 benefits 5/	6,486	---	697,065	---	27,346	27,973
Primary	6,221	---	676,107	39.83	26,927	27,540
Wives	265	---	20,958	19.97	418	434
Lump-sum death payments 6/	106,478	237.71	---	---	---	23,793

1/ Exceeds monthly rate of benefits in current-payment status because of the inclusion in initial payments of amounts payable for prior months. Distribution by type of monthly benefit estimated.

2/ Includes wives under age 65 with entitled children in their care; a total of 377,000 such wives of retired and disabled workers were in current-payment status.

3/ Includes disabled persons aged 18 and over whose disability began before age 18.

4/ Includes widows and divorced wives aged 60-61 entitled under the 1965 amendments and disabled widows and widowers aged 50-61 entitled under the 1967 amendments.

5/ Represents benefits authorized by Public Law 89-368(1966) for certain persons aged 72 and over who are not insured under the regular or transitional insured-status provisions of the Social Security Act.

6/ Number of lump-sum payments shown were paid on the accounts of 100,093 deceased workers; the average amount represents average per deceased worker.

INDEX OF AUTHORS AND SUBJECTS

Volume 6 1968

AUTHORS

Alterman, Arthur
The ITPA Test (review of *Interpretation of the 1961 Illinois Test of Psycholinguistic Abilities* by Barbara D. Bateman) Nov-Dec 20

Arnaudo, Patricia
See Reid, Otto M.

Baker, Marilyn
The Culture of Youth (review of *The Culture of Youth* by Marvin E. Wolfgang), Jan-Feb 22-23

Bateman, Worth
Assessing Program Effectiveness: A Rating System for Identifying Relative Project Success, Jan-Feb 1-10

Carter, Genevieve W.
The Employment Potential of AFDC Mothers: Some Questions and Some Answers, July-Aug 1-11

Chilman, Catherine S.
Attitudes Toward Family Planning (review of *Sociological Contributions to Family Planning Research*, Donald J. Bogue, ed.), July-Aug 22-25

Coll, Blanche D.
Perspectives in Public Welfare: Colonial Times to 1860. Part II: Outdoor Relief, Unemployment Relief, Causes of Dependency, and Voluntary Agencies, July-Aug 12-22

Cowhig, James D.
White-Nonwhite Income Differences, 1966, Mar-Apr 19-21

Cox, Irene
Families on Welfare in New York City, Mar-Apr 22-26

Eppley, David B.
Decline in the Number of AFDC Orphans: 1935-1966, Sept-Oct 1-7

Fascione, Daniel
See Moles, Oliver

Hess, Robert F.
See Moles, Oliver

Hougham, George M.
See Stein, Herman D.

Levine, Abraham S.
Rehabilitating Disabled Welfare Recipients: A Cost-Benefit Analysis, Sept-Oct 14-18

Moles, Oliver, Robert F. Hess, and Daniel Fascione
Who Knows Where To Get Public Assistance? Sept-Oct 8-13

Morse, Harold A.
Measuring the Potential of AFDC Families for Economic Independence, Nov-Dec 13-18

O'Donnell, Edward J.
The Neighborhood Service Center: A Place To Go and A Place To Be From, Jan-Feb 11-21

Reid, Otto M., Patricia Arnaudo, and Aurilla White
The American Health-Care System: A Social Organizational Point of View, Nov-Dec 1-12

Reno, Philip
See Therkildsen, Paul

Stein, Herman D., George M. Hougham, and Serapio R. Zalba
Assessing Social Agency Effectiveness: A Goal Model, Mar-Apr 13-18

Therkildsen, Paul and Philip Reno
Cost-Benefit Evaluation of the Bernalillo County Work Experience Project, Mar-Apr 1-12

White, Aurilla
See Reid, Otto M.

Zalba, Serapio R.
See Stein, Herman D.

SUBJECTS

Aid to Families With Dependent Children (AFDC)
Assessing Program Effectiveness: A Rating System for Identifying Relative Project Success, Jan-Feb 1-10
Cost-Benefit Evaluation of the Bernalillo County Work Experience and Training Project, Mar-Apr 1-12
Decline in the Number of AFDC Orphans: 1935-1966, Sept-Oct 1-7
The Employment Potential of AFDC Mothers: Some Questions and Some Answers, July-Aug 1-11
Families on Welfare in New York City, Mar-Apr 19-21
Measuring the Potential of AFDC Families for Economic Independence, Nov-Dec 13-18
Rehabilitating Disabled Welfare Recipients: A Cost-Benefit Analysis, Sept-Oct 14-18
The Social Security Amendments of 1967: Welfare and Child Health Provisions, May-June 1-34
The Validity of Interviews With AFDC Mothers, Sept-Oct 18-19

Cost-Benefit Analysis
Cost-Benefit Evaluation of the Bernalillo County Work Experience and Training Project, Mar-Apr 1-12
Rehabilitating Disabled Welfare Recipients: A Cost-Benefit Analysis, Sept-Oct 14-18

Employment (*see also* Work Experience and Training Program)
The Employment Potential of AFDC Mothers: Some Questions and Some Answers, July-Aug 1-11
Families on Welfare in New York City, Mar-Apr 22-26
Measuring the Potential of AFDC Families for Economic Independence, Nov-Dec 13-18
Rehabilitating Disabled Welfare Recipients: A Cost-Benefit Analysis, Sept-Oct 14-18

Evaluation
Assessing Program Effectiveness: A Rating System for Identifying Relative Project Success, Jan-Feb 1-10
Assessing Social Agency Effectiveness: A Goal Model, Mar-Apr 13-18
Cost-Benefit Evaluation of the Bernalillo County Work Experience and Training Project, Mar-Apr 1-12
Measuring the Potential of AFDC Families for Economic Independence, Nov-Dec 13-18
Rehabilitating Disabled Welfare Recipients: A Cost-Benefit Analysis, Sept-Oct 14-18

Family Planning
Attitudes Toward Family Planning (book review), July-Aug 22-25

Health Care
The American Health-Care System and the Poor: A Social Organizational Point of View, Nov-Dec 1-12

History (*see* Social Welfare, History of)

Income (*see also* AFDC, Low-Income Persons, Poverty, Work Experience and Training Program)
The Employment Potential of AFDC Mothers: Some Questions and Some Answers, July-Aug 1-11
The Social Security Amendments of 1967: Welfare and Child Health Provisions, May-June 1-34
White-Nonwhite Income Differences, 1966, Mar-Apr 19-21

Juvenile Delinquency
The Culture of Youth (book review), Jan-Feb 22-23

Language Learning in Children
The ITPA Test (book review), Nov-Dec 20

Low-Income Persons
The American Health-Care System and the Poor: A Social Organizational Point of View, Nov-Dec 1-12
Attitudes Toward Family Planning (book review), July-Aug 22-25
Who Knows Where To Get Public Assistance? Sept-Oct 8-13

Neighborhood Service Centers
The Neighborhood Service Center: A Place To Go and A Place To Be From, Jan-Feb 11-21

Orphans
Decline in the Number of AFDC Orphans: 1935-1966, Sept-Oct 1-7

Poverty (*see also* Low-Income Persons)
Perspectives in Public Welfare: Colonial Times to 1860, Part II, July-Aug 12-22
White-Nonwhite Income Differences, 1966, Mar-Apr 19-21

Public Assistance (public welfare) (*see also* AFDC)
Perspectives in Public Welfare: Colonial Times to 1860, Part II, July-Aug 12-22
Public Opinion and Public Welfare, Nov-Dec 19

The Social Security Amendments of 1967: Welfare and Child Health Provisions, May-June 1-34
Who Knows Where To Get Public Assistance? Sept-Oct 8-13

Public Welfare Agencies
Assessing Social Agency Effectiveness: A Goal Model, Mar-Apr 13-18
Measuring the Potential of AFDC Families for Economic Independence, Nov-Dec 13-18

Research and Demonstration Projects
The American Health-Care System and the Poor: A Social Organizational Point of View, Nov-Dec 1-12
The Cooperative Research and Demonstration Grants Program: A Report for Fiscal Year 1968, July-Aug 26-32
Cost-Benefit Evaluation of the Bernalillo County Work Experience and Training Project, Mar-Apr 1-12
The Culture of Youth (book review), Jan-Feb 22-23
The Employment Potential of AFDC Mothers: Some Questions and Some Answers, July-Aug 1-11
Families on Welfare in New York City, Mar-Apr 22-26
The Neighborhood Service Center: A Place To Go and a Place To Be From, Jan-Feb 11-21
Public Opinion and Public Welfare, Nov-Dec 19
Rehabilitating Disabled Welfare Recipients: A Cost-Benefit Analysis, Sept-Oct 14-18
The Social Security Amendments of 1967: Welfare and Child Health Provisions, May-June 1-34
The Validity of Interviews With AFDC Mothers, Sept-Oct 18-19

Research Methodology
Assessing Program Effectiveness: A Rating System for Identifying Relative Project Success, Jan-Feb 1-10
Assessing Social Agency Effectiveness: A Goal Model, Mar-Apr 13-18
Cost-Benefit Evaluation of the Bernalillo County Work Experience and Training Project, Mar-Apr 1-12
The Validity of Interviews With AFDC Mothers, Sept-Oct 18-19

Social Organization Theory
The American Health-Care System and the Poor: A Social Organizational Point of View, Nov-Dec 1-12

Social Security Amendments of 1967
Welfare and Child Health Provisions of the Social Security Amendments of 1967: Legislative History and Summary, May-June 1-34

Social Welfare, History of
Perspectives in Public Welfare: Colonial Times to 1860, Part II, July-Aug 12-22

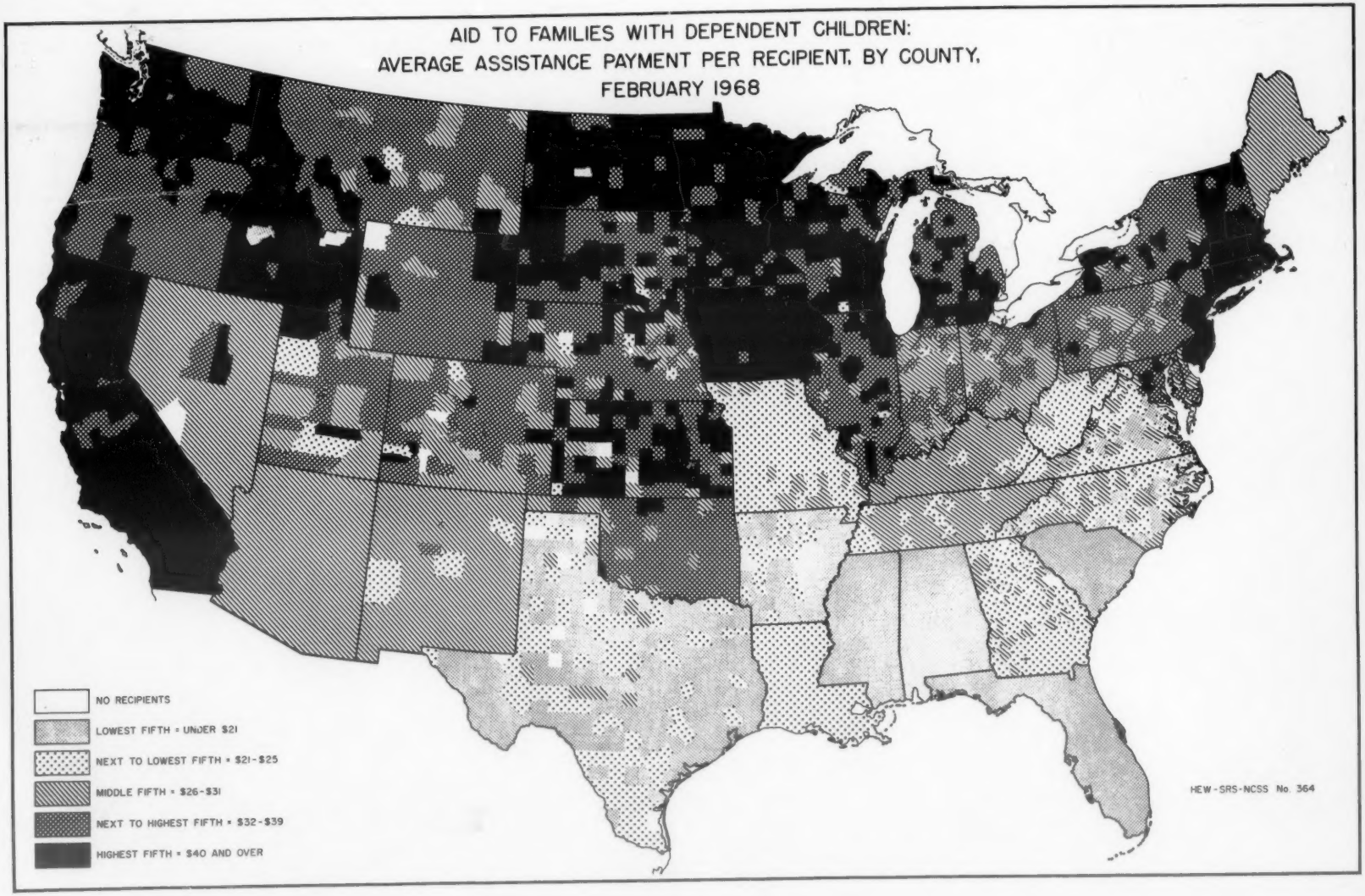
Vocational Rehabilitation
Rehabilitating Disabled Welfare Recipients: A Cost-Benefit Analysis, Sept-Oct 14-18

Welfare (*see* AFDC, Public Assistance, Social Security Amendments, and other headings)

Work Experience and Training Program
Assessing Program Effectiveness: A Rating System for Identifying Relative Project Success, Jan-Feb 1-10
Cost-Benefit Evaluation of the Bernalillo County Work Experience and Training Project, Mar-Apr 1-12
Rehabilitating Disabled Welfare Recipients: A Cost-Benefit Analysis, Sept-Oct 14-18

Young People
The Culture of Youth (book review), Jan-Feb 22-23

☆ U. S. GOVERNMENT PRINTING OFFICE : 1968 344-643/3

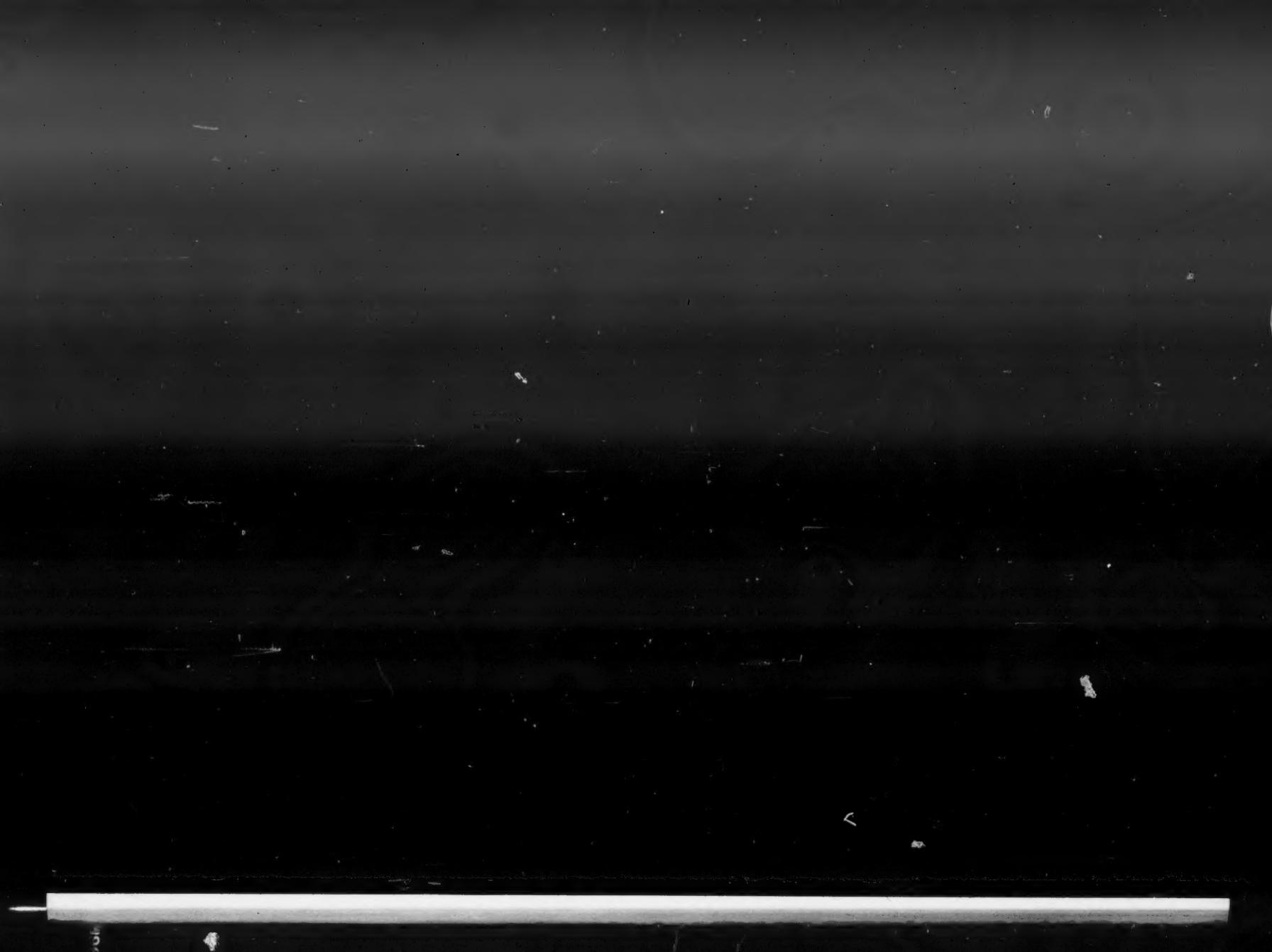

AID TO FAMILIES WITH DEPENDENT CHILDREN:
AVERAGE ASSISTANCE PAYMENT PER RECIPIENT, BY COUNTY,
FEBRUARY 1968
NO RECIPIENTS
LOWEST FIFTH = UNDER $21
NEXT TO LOWEST FIFTH = $21-$25
MIDDLE FIFTH = $26-$31
NEXT TO HIGHEST FIFTH = $32-$39
HIGHEST FIFTH = $40 AND OVER
HEW-SRS-NCSS No. 364

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Social and Rehabilitation Service
WASHINGTON, D.C. 20201

POSTAGE AND FEES PAID
U.S. DEPARTMENT OF H.E.W.

OFFICIAL BUSINESS

November--December [illegible]
Volume 6--Number 6

U. S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Social and Rehabilitation Service

C